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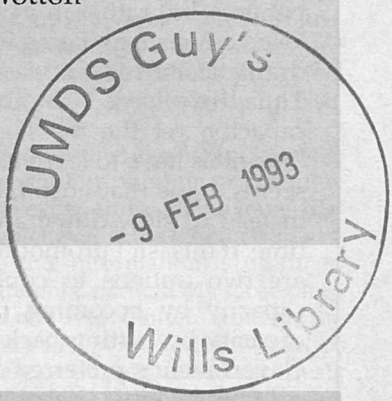
CONTENTS

2 **Passim**
3 **Letters**—McDonald's, Hop
8 **News**—research rating, Garibaldi
10 **Pre-clinical course**—Dr Papachristodoulou
14 **New Cross**—Dr Pitt-Payne's time there
22 **Berlin Conference**—SMEC reports
26 **407 Art Club**—some of the exhibits
28 **'You've got it!'**—a poem by Bruce Wotton
30 **Reviews**—medicine, gynae
31 **Nursing Notes**—euthanasia
33 **Clubs Union News**—Diwali
34 **Sport**—rugby and boat clubs
42 **Classified and Announcements**



Guy's Gazette

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The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

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Passim

As I write this passim, London's hospitals, indeed Londoners themselves await with baited breath the Government's response to Sir Bernard Tomlinson's report. The previous round of changes to the health service, in the form of the internal market have been somewhat longer established. Though much maligned in some quarters, I must say they have had some benefits, like demonstrating that money, or rather lack of it, is the cause of many of the problems in the health service.

The media are currently reporting a 'cash crisis' in the NHS. Elective procedures are not being performed, theatres and staff are lying idle in many of the country's hospitals. This is certainly not from a lack of patients, but rather from a funding shortage. Hospitals have in the past faced criticism for being inefficient, and in many cases have been able to dramatically reduce waste through better management of resources. Thus, they have been able to see more patients and still have spare capacity, yet the message now filtering down to the troops is that 'hospitals have to learn to live within their means'. In practical terms, it seems to me that hospitals are being asked not to fulfil their potential, instead to slow down and see fewer patients in any given period of time. If this isn't promoting inefficiency, then I'm not sure what is! There are two options to cope with hospitals which have found 'extra' capacity by becoming more efficient; increase funding, or reduce capacity by cutting back on beds and staff. It would appear that the Government's preferred course of action is the latter.

I guess you've probably noticed the new cover by now. When I first mooted the idea of a new design, I was greeted with some incredulity. Given the recent history of *Gazette* covers this reaction might be justifiable and one might argue that I was being a trifle foolish in changing a generally well received design. I have attempted to keep the best of the last cover, and incorporate some more elements of Guy's 'corporate' image. I do hope that this design will be as 'successful' as the previous one.

Travel finance

Dear Sir,
Currently, the LEA grant awards have a fixed proportion of their awards dedicated to travel expenses. Travel not only implies travel from place of residence to college but, in the case of clinical students, to other medical institutions.

The cost of travelling for most students far exceeds the amount fixed in their grant awards. The main reason for writing this letter is to inform students that local authorities do have the means of reimbursing travel expenses.

This not only includes travel to other medical institutions within the UK but also to foreign centres. The latter is of relevance during the elective period. This information is contained in handouts given to all medical school registries and which are meant to serve as advisory notes.

The guidelines suggested by these notes are under the heading of 'special expenditure'. Special expenditure implies expenses met while travelling 'within and outside the UK for the purpose of attending a foreign institution, including necessary travel abroad'. This suggests to me that a certain amount of the travel expenses to foreign institutions and within a foreign country incurred by an elective student could be reimbursed. In addition, it seems that the cost of medical insurance against liability (in countries which have no reciprocal public health arrangements with the United Kingdom) and costs incurred while trying to obtain visas and medical tests (where these items are a mandatory condition of entry into the host country) again, could be reimbursed.

Appendix 9 of the advisory notes points out how to work out the special expenditure which is to be reimbursed:

Special expenditure = Total expenditure - Travel disregard

The travel disregard is the fixed amount of money allocated for travel expenses and which makes up a small proportion of an individual's LEA award. For those students receiving an award and living with their parents, the travel disregard is £207. For those living elsewhere, it is £133.

The reimbursement value is either the special expenditure amount or the value of the total expenditure minus travel disregard, whichever is the *lesser*.

I hope this information is useful to clinical students, particularly those planning their electives. It offers students the opportunity of having not only part of their air fares, visa costs and medical tests refunded but also that of medical insurance (important for example in North America). I do however recommend that you write to your own Local Education Authority asking them about their policy.

Yours faithfully,

Abbi Lulsegged
BMA Representative
Boland House
Guy's Hospital

Big Mac and fries

Dear Sir,
With the opening of the new McDonald's in Boland House we see the beginning of a new era for Guy's Inc, but who was ever consulted about this plastic fast food restaurant to be slotted into the stonework

of Boland House, opposite the chapel and under the house officers' living quarters? There is no doubt that the restaurant will be frequented by inpatients, outpatients, hospital visitors and staff, and does this mean that we are to be subjected to active encouragement to eat there through publicity campaigns, promotions and discount coupons for hospital staff? For those that choose not to eat there does this mean that they will have to put up with the curtailment of other hospital canteen hours, and the increase in prices?

Everyone knows the long time house officers and other doctors on-call are imprisoned in the hospital—are they condemned to a life of Big Mac and fries, and a bed over the restaurant? Agreed that the increased consumption of meals high in calories, fat and sodium, and low in fibre and vitamins may be a relatively minor problem, but more serious are the symbolic implications of a major teaching hospital not only condoning, but actually endorsing the consumption of fast food.

Hospitals are entrusted not only to heal the sick but also to promulgate health maintenance and disease prevention. The importance of nutrition in preventing disease is well recognised and dietary factors are possibly the easiest risk factor to modify. Ideally all hospitals should provide a model on which the public can modify its diet. By endorsing unhealthy eating practices, this hospital has traded its duty to the community for pecuniary advantages.

Yours faithfully,

DONALD FRY
Boland House
Guy's Hospital

Rugby Club Hop

Dear Sir,

I write to join with Shahid Khan and Smita Patel in expressing my dismay at the incidents described at the Rugby Club Hop on 6 November 1992. I understand that the Rugby Club dispute that the letters placed on the back of the hands of some of the correspondents were intended to be interpreted in this way, but nonetheless, it is important that irrespective of the intention, the greatest care should be taken to prevent the possibility of such misunderstandings arising. If there was such an intention, even as an isolated incident, then this is simply not tolerable in our society generally and certainly not in our schools or hospitals. I offer, therefore, my personal apologies and that of the School as a whole to those who were the victims of the offence, and assure all members of the School, both students and staff, that no form of racial or other abuse to individuals is tolerable within UMDS.

Perhaps I could point out as a general point that racial abuse, whether verbal or physical, is unlawful and disciplinary action will most certainly be taken by the School against any individual found guilty of perpetrating such abuse.

I am confident that the general body of students and staff share my opinions concerning these matters.

Yours faithfully,

CYRIL CHANTLER
Principal, UMDS
Dean's Office
Guy's Hospital

Unacceptable attitudes

Dear Sir,
With reference to the racism that is alleged to have occurred at the Hop on Friday 6 November 1992. We would like to make it absolutely clear that the Amalgamated Clubs will not tolerate such unacceptable attitudes, and that students who hold these beliefs should keep them to themselves, or find other courses and colleges at which to study.

Yours faithfully,

RICHARD PROBERT
WILLIAM FRANCIS
UMDS Campus Student Presidents
Boland House
Guy's Hospital

Misinterpreted abbreviations

Dear Sir,
I was deeply upset by the letters in the December issue of the *Gazette* accusing members of the rugby club of racism on the night of 6 November 1992. I myself was on the door of the Hop that night and several letters and symbols were marked on students' hands to allow them re-entry after they paid. These markings ranged from rugby balls to common medical abbreviations such as FBC (full blood count) and PT (prothrombin time). I am sure that any combination of these letters could be, with a little imagination, interpreted as representing insulting phrases. However they were not, and I am sorry if certain people misinterpreted these harmless letters and symbols as a racist attack.

Guy's RFC is by far the largest club at UMDS and, as all players and supporters know, we welcome all with the spirit of rugby at heart without any form of discrimination whatsoever, even that of playing ability!

Yours faithfully,

RICHARD DALES
Fixture Secretary
Guy's Hospital RFC
Boland House
Guy's Hospital

Hen story

Dear Sir,
I was so pleased to read the account of the alimentary journey of a denture tooth described by Stephen Johns in the October issue of the *Gazette*. I well remember the occasion as Flt Lt Johns was well known for his ingenuity. I am sure he well remembers another episode of that same period when I was his Dental Clerk Orderly. The young Flt Lt felt it was most important to have a ready supply of fresh eggs but these were difficult to obtain in the Canal Zone, and were of doubtful origin if bought locally.

Flt Lt Johns devised and constructed a small hen coop under the hut which accommodated the dental surgery where we worked. Access to this dungeon, in which the unfortunate hens had to spend their wretched lives, was through a trap door in the surgery. All went well with this scheme until the AOCs inspection of the surgery when it was difficult to disguise the noise from the birds. Resource-

full as ever, the young Flt Lt started singing songs from Gilbert and Sullivan to his patients to drown the clucking from below his feet. He had, I remember, a fine baritone voice.

It was only by pure chance that Stephen Johns letter to the *Gazette* was brought to my attention by a former fellow officer of that time. I do hope that he remembers the episode and the names he gave the hens: Rita, Hilda and Doris.

Yours faithfully,

RITA FISHER (née Sole)
1 Undercliff Gardens
Ventnor

Who is Vaour?

Dear Sir,

On reading Physiotherapy Notes for November I asked myself: 'Who is this *Vaour* person?' Was he the leader of the young men bull-vaulters in Crete? Has the editor popped in this piece of fascinating information, or is it a deliberate mistake? Maybe Vaour did exist, but the Physiotherapy Notes copy read 'Vault of Valour' purely as a descriptive comment.

Yours faithfully,

DIANA INNOCENTI
Physiotherapy Department
Guy's Hospital

Thank you

Dear Sir,

I would like, through the medium of the *Gazette*, to thank all my friends and colleagues who contributed so generously to celebrate my 50 years at Guy's and to many who wrote letters of good wishes. I was delighted to see so many of my old friends at the reception which was held in the Roben's Suite on 27 October organised by the Department of Neurology.

Yours faithfully,

NORA RELIHAN
Neurology Department
Guy's Hospital

Guy's Hospital East Anglian Society

Dear Sir,

May I through the courtesy of your publication bring to the notice of all Guy's graduates in East Anglia that the 22nd biennial dinner of this society will be held on Saturday 24 April 1993. The venue is the Sainsbury Centre for the Visual Arts at the University of East Anglia. Dr A Batty Shaw will preside and the Guest of Honour is Mr John Maynard. Details will have been sent to all graduates on my mailing list. If there are any Guy's graduates who have not received such communication and would like to come this year or on subsequent years please notify me at this address.

Yours faithfully,

B A ROSS
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Central Research Fund

The Central Research Fund has been instituted for the purpose of making grants to members of the University (other than the present undergraduate students and those registered for a taught Master's degree) engaged on specific projects of research, to assist with the provision of special materials, apparatus and travel costs. Applications are considered each term and the next closing date for applications is 22 March 1993. Forms of application and further particulars may be obtained from Mrs L J West at Central Research Fund Section, Academic Division, Senate House, Room 21a, Malet Street, London WC1E 7HU. Tel (071) 636 8000 ext 3147.

Research rating

UMDS has performed extremely well in the recently announced assessment of research faculties undertaken by the Universities Funding Council. Compared to the 175 universities, polytechincs and colleges taking part, UMDS came 10th overall, obtaining the maximum score of 5 for the dental school and improving in clinical medicine from 3 at the last assessment to 4 on this occasion. The pre-clinical rating stayed the same at 3. Oxford, Cambridge and University College were the only schools to score higher in clinical medicine, and the dental schools at UMDS and the London Hospital were the only colleges to get a score of 5 for clinical dentistry.

Deans' Board

On 8 October, four deans (past and present) of the dental school, together with many of the consultant staff of the dental hospital, gathered to witness the unveiling, by Professor Ron Emslie, of a splendid board bearing the names of the six deans of the dental school at Guy's Hospital. The Deans' Board was very generously donated by Professor Jack Rowe and is situated outside the Dean's Office on Floor 27 of the Tower, adjacent to the board bearing the name of the dental surgeons to Guy's Hospital.

Professor Frank Ashley, Professor Jack Tulley, Professor Ron Emslie, Professor Jack Rowe pictured with Ann Webster who has been secretary to them all.

Evelina Children's Hospital Appeal

November 26 was an important day for the Guy's Evelina Children's Hospital Appeal, as we honoured the Great Garibaldi, the international clown, at the Elephant and Castle Shopping Centre, thanks to the generous hospitality of Mike Loseby, the Manager.

For the past 3 years, Garibaldi has attended scores of events, such as Wimbledon, the Derby, the Bluebell Railway and the London Marathon in order to reach his original target of £20,000 in aid of our charity.

A final figure of £22,000 was raised, thanks to a generous donor who enabled us to exceed the target.

Lady Harris kindly accepted the cheque on behalf of Guy's and in congratulating Garibaldi, pointed out that the money raised has helped nurses and doctors treat more babies in the Paediatric Intensive Care Unit.

In addition to being a great clown (as can be seen from the picture), Garibaldi has many other attributes, and one of his most recent has been playing an accordion for 90 hours from 4-8 June 1991 at the Elephant and Castle Shopping Centre, with an entry in the 1992 *Guinness Book of Records*, page 208.

Nursing staff may like to know that there is an entry in the same volume on the next page for the pair record for bed making with one blanket, two sheets, an under sheet an uncased pillow, one counterpane and hospital corners, in a total time of 17.3 seconds.

Many thanks again to Garibaldi and may we wish you a very happy retirement.

M Joseph and S Sutton

From left to right: Harry Guy, Garibaldi and Lady Harris

Integrated Pre-clinical

Dr Papachristodoulou talks about its implementation

Everyone seems to have an opinion on the new system-based, integrated pre-clinical curriculum that has been implemented at Guy's. When changes as fundamental as these are implemented, there are bound to be some teething problems. In this interview, I examine the aims of the organisers, and how they see the implementation progressing.

What is your role in the new pre-clinical curriculum changes?

A liaison committee was formed, which consisted of one representative from each pre-clinical department plus the pre-clinical dean, to formulate a plan for the changes, and I was asked to coordinate that committee and work on the courses proposed by the organisers, and develop a time-table. Then I was asked to see that it worked.

Why do you think there was a need for a new curriculum?

Mainly to reduce the number of lectures and increase free-time to learn and digest material taught; to reduce repetition in the teaching; to concentrate on basics and on understanding; and also to go along with the General Medical Council's suggestions about how basic medical education should be developing. Several other medical schools in London have also changed, or are changing, to similar systems-based pre-clinical curricula; for example, the London.

Do you think that a system-based approach is a better teaching model for future clinicians?

It is more logical and it is also the way the clinical course is taught.

What aspects of the new course do you think are particularly good?

The 'communications and learning' module at the beginning of the first year, the early introduction of students to the hospital and the increase in clinical input in the course, such as the clinical demonstrations. In addition the coordination of dissection with the function of the various systems, and more time being provided for learning are valuable improvements.

Presumably the end of year exams will be quite different to past pre-clinical papers. This often causes confusion among students about what they need to know. Can you help them get around this problem?

The exams will be different, but will reflect the teaching, and external examiners will also be familiar with the new curriculum. Students have been given booklets with sample questions and are also given specific learning objectives with every teaching block.

There have been some complaints, particularly by 2nd years, that tutors cannot teach or explain problems outside their own area of expertise; for example, a physiologist chairing a tutorial in which problems with a biochemical slant are discussed, often has little knowledge on biochemistry and cannot really help.

We try to ensure that each tutorial group will have specialist tutors in the topic they are being taught on at the time. Also, tutorial should not be lectures where the tutor simply tells students the answers, but should be an opportunity for students and teachers alike to discuss basic science problems.

Another common 2nd year complaint is that they had only 4 weeks to do the head and neck, substantially less than previous years. How do you respond to that?

Well, there will be special head and neck revision tutorials before the end of year exams and that is all we can do this year. Next year the head and neck course will be modified to take this into account.

What advice would you give students having problems with textbooks which are generally written in a subject based style?

Yes, this is a problem, but as more medical schools adopt a systems-based approach, corresponding integrated textbooks will appear. In the meantime, course organisers and lecturers have recommended core textbooks that, supplemented by lectures and tutorials, have all the information the student requires.

I would also like to say that a lot of the problems, particularly with the 2nd years, are not problems of the new curriculum but rather problems of the transition. Thus, this year's 1st year will have a relatively easier time next year. Logistically, it would have been extremely difficult to keep the old system for the 2nd years and yet tie in with the current 1st years.

Is there anything you would like to say about the new curriculum?

I hope it works!

How will you know if it has worked?

By student opinion, by exam performances and, of course, how we as teachers feel about it. The progress of the curriculum is continually discussed amongst staff.

We are always looking for feedback on the changes. All students were given questionnaires in which they were invited to express their views on the new course. As this is only the first year of the new curriculum, we need student opinion to improve it. Questionnaires are also being provided at the end of each course.

Pre-clinical students must feel free to contact their lecturers, tutors and myself with any problems. If they are confused by anything or they don't understand something they must ask. We are always willing to listen and help. *Thank you.*

S A Khan

Copy for the *Gazette*

Articles for inclusion in the *Gazette* should be supplied double spaced, and preferably word-processed or typed. If handwritten, names in particular should be written legibly. If contributions are prepared on a word-processor, it would be particularly helpful if a floppy disk containing the article is supplied along with a printed copy. Where possible, text should be saved in ASCII format—or if in any doubt, full details about compatibility of different files can be obtained from the *Gazette* office.

All feature articles should be received by the dates below, and should be approximately 1,500 to 2,500 words in length. Late news and sports reports can usually be accepted upto one week later. This deadline may also be extended by agreement with the editor. Authors are requested to supply a contact phone number in case of any queries that arise. The *Gazette* would also particularly welcome results of any original research carried out in the course of BSc or other project work. Final year students are requested to send in material about their electives—even if it only consists of anecdotes.

So, now you know what to do to get your name in print—get writing!

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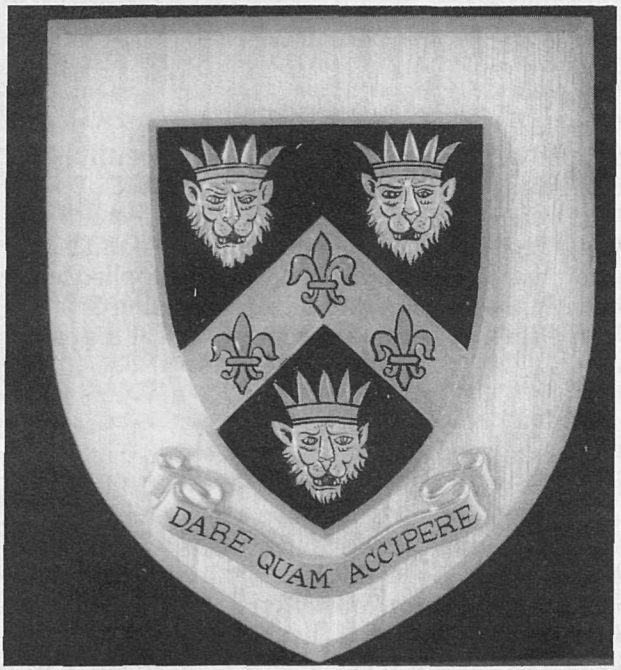

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Time at New Cross

From breast to brain

I have always been mystified at the way fate took me by the scruff of the neck and propelled me through life especially when I was at Guy's. No one knew of my pet aversion—which was blood, of course—and it was an irony that I should have landed up in a job where there was so much of it together with the close proximity to the stuff, which, if wrongly applied to the sundry cut or abrasion could cause the yellow jaundice, fulminating or otherwise, with or without the complications of the wooden overcoat at the end of the line.

A finger in the dyke

Mr Frank Ellis did a lot of arterial surgery and I was glad indeed that he did, but to be on call for his firm that night after these femoro-popliteal by-pass things was a worry in case something came undone. During my time with Sir Hedley Atkins all was well and it wasn't until I worked for Dr Willy Mann that the unthinkable happened. It was two o'clock in the morning and I was resting in Casualty—an excellent place for coffee at all hours—and I was sitting with John Storrs (T J Storrs—now consultant oral surgeon at the Kent and Canterbury Hospital) when his bleep went off in that rather urgent sort of way the bleeps used to go off when things had gone terribly wrong. All was quiet on Miriam and Mary wards in Hunt's House so I thought I'd tag along with John and take a bit of a gander at whatever it was that had hit the fan on Astley Cooper ward. John was Sir Hedley's last HS and when we got there we found that things were—to put it mildly—somewhat fraught. One of these femoro-popliteal operations had come apart in the groin. I invited the nurse to remove her hand from the wound and there was a fountain of blood that gushed over the end of the bed. As I was first there, I put my thumb quite unthinkingly in the wound site and got liberally splattered with blood for my pains. It put me in mind of the small boy who once put his finger in a dyke in Holland—but that's another story. From there on, everything went smoothly and we waited for the registrar to arrive and insert the sterile clamp in the right place. This done, I was free to go—and I pondered on the fact that I had acted so unthinkingly and not felt the grey mist rising to blot out my sense of consciousness.

Off to the New Cross Breast Unit

My time at Guy's was nearly done and I was none the worse for the experience—but it had not always been so. It was a pleasant relief to go off to New Cross Hospital to the brand new purpose-built Breast Unit where D F A Richards (late of Granville House, Epsom College) had been locum. Richards had a passion at that time for making various sculptures and I would have had his room in the doctor's quarters were it not for the fact that the place was untenable as living quarters. He had manufactured a messy nightmare for the cleaners because of his use of plaster of Paris and chicken wire to create works of art. The only sign that he had lived there like some latter day Gauguin was the carpet which was so thick with plaster of Paris that it had to be thrown away.

The mess at New Cross was run by a trio of ladies whom I remember as Kitty, Eileen and Barbara. These three women watched the antics of their charges with great interest as though we might have been a breed apart and Richards certainly came as something of a shock for them. When I arrived with my piano accordion, my black and yellow umbrella, and my rag-making kits, they must have heaved a sigh of relief in the hope that I might be a tidier bet than my predecessor. I had taken to rug-making as a form of therapy and I had become quite proficient at it; believing as I indulged in my new-found passion that I had found a way of building a home for myself in the future. My plans for making such a dwelling had been shattered when a blue-eyed leggy blonde called Jacqui Cray came into my life on 28 July 1970. I couldn't have been paying attention. I had been sort-of aware of her as she appeared at my side on my weeks on take-in and she had seemed very helpful but I had given it no further thought. She was far too attractive for me and her eyes were of the brightest blue. I had resigned myself to a life of solitude and was determined to make the best possible job out of the opportunities that had come to me. Treasurership of the Residents had been a fly in the ointment, I reasoned, but the monthly parties were a chore that had to be managed and I had manned the bar one night for an hour and a half when I saw Ian Morgan (I J Morgan late of Forest House, Epsom College) arrive.

'I say, Morgan, old chap...,' I wheedled, 'you wouldn't care to help me out here, only I've been at it for an hour and a half.'

At that precise moment, Jacqui Cray and Jane Bragg, staff nurses on Casualty, had walked in and I, despairing of my lack of social prowess, decided that it was time to dance and be something of the lounge-lizard my father had never wanted me to be.

'I say,' I began, 'would one of you two girls care to dance?'

'Yes please,' said the taller of the two, 'I'll dance with you.'

It was Jacqui Cray.

'Ah.' I muttered. 'Alright then...' I led her into the Residents' Lounge where something akin to Dante's Inferno was going on with flashing lights, loud music, and the kind of infernal racket chaps make when they're having a good time. We danced and in no time at all I knew that something had happened to me. I'd met my wife.

And now for a bit of culture

I didn't know it at the time but 22 years later we are still together and the realization as to what had happened to me dawned with horrifying slowness. I was also rather naive in the ways of women, so when I said: 'Would you care to come up to my room and listen to a record I bought today?' I should not have been surprised at the hesitation she showed in the face of such an invitation which tanged of etchings and other such nameless horrors. I had in fact, purchased a record of Mario Lanza singing at the top of his voice. Elsewhere, readers will have learned of my love of a bit of culture from time to time. I much enjoyed the singing of Mario Lanzo and oft tried to emulate his talents in the bathroom—and failed. We sang a lot in those days, you see, and there were several of us who liked the rather special acoustics available to us in the first floor gents toilets in Hunt's House where there was a high ceiling and lots of tiles thus making for a very fine echo with bags of resonance. Many's the time Graham Hey, Dave Elliot, John Soul, Graham Voss, and myself repaired to the said bogs in the Medical Block in the early hours of the morning and gave that fine old hymn, 'Abide with me, fast falls the eventide,' a good hammering. No one ever complained because they never heard us and if they did it was off limits to Night Sister and her charges. I suppose we must have been under enormous stress but I can honestly say that I have no recollections of it because of the great sense of togetherness we all shared as members of the Medical Mess. They were very happy times and there were constant late nights where we would tumble into bed at three o'clock only to rise three to four hours later and begin another hectic day.

My three months at New Cross Hospital came as something of a break from the hurly-burly of the Guy's routine. The food was very passable. The rooms were warm and the working conditions very pleasing although the hospital seemed to be a bit sprawled about but in all my time in hospitals, I never went in one that wasn't. There were covered walkways between the wards and only the Breast Unit stood alone in its newly-built splendour. I was sorry to hear that it is no more but in those days we certainly knew how to turn over our cases at a high rate of knots. Patients were seen in the Guy's Breast Unit the previous week and admitted on the Tuesday evening for excision biopsy the

following day. There would be anything up to 10 operations on the Wednesday and the poor women had to wait for the ritual of the ward round on Friday morning conducted by Mr Hayward, who would have the results fresh from the path lab in his hands. John Hayward proved to be an excellent boss, always careful and caring towards his patients and he had developed a way of telling them the worst in a straightforward way which I watched and have tried to emulate ever since. Those for whom the tumour was benign were able to go home and those for whom a further operation was essential were put on the Monday afternoon list. This pattern each week hardly ever varied and the women who had undergone mastectomy the previous Monday afternoon always rallied round those shocked by the news they had just received. It wasn't long before I'd begun a group therapy session on the Friday afternoons where constructive work was done and I tried to understand the nature of the awful trauma these women went through in order that their lives might be saved.

Ivor Broomhead, consultant plastic surgeon, did his operating sessions on Monday mornings and in the short time I was with him I saw him do so many things and display so many skills that I developed a new respect for the art of the plastic surgeon. He was a consummate artist and his results were uniformly impressive. Although he had only eight beds at New Cross, four male and four female, they were always fully utilized. I was also able to see the rapid turnover in knee surgery thanks to the new arthroscopy Adrian Henry had brought back with him from the USA. Knee surgery was being transformed before our very eyes. Patients limped in and walked out the following day. This was progress indeed.

I think the operation which turned me off the most was the rhinoplasty and holding the patient's head whilst this sawing procedure up the snout was taking place was a gut-churning business. Then there'd be an appalling cracking sensation when the fractures were carried out. Quite disgusting it was, but a few days later the result had Belisha-beacon hairstyles going out of fashion as the hair went up and the hair-pins went in.

One case at Guy's I shall always remember was the brain haemorrhage following head injury that occurred in a man who had been hit over the head with a crowbar wielded by a miscreant who was carrying out a robbery at the time. We had asked for 10 minute observations on him as he was unconscious, and with the mandatory policeman sitting by the bed: notebook at the ready taking down everything that was said. Laughable it was in some ways, because every time we asked him how he was the copper in question had to record our questions in case there was an answer. Then one pupil became widely dilated and the pulse dropped dramatically. It's always eerie when it

happens just as the textbooks have always said it would, but happen it did, and I got on to C B T Adams, senior registrar in neuro-surgery to Mr Murray Falconer. He arrived in double-quick time, carried out his examination and then rang Mr Falconer to gain the necessary permission to perform the craniotomy. It was my first and last taste of brain surgery and I came to know the alliterative meaning of a 'brilliant brain surgeon'. I never heard of a brain surgeon who wasn't brilliant, but brilliant Mr Adams was and a life was saved. The haemorrhage had depressed the brain inwards by some four centimetres and I gained a new respect for the middle cerebral artery. The recovery was dramatic and that patient walked out of hospital some five days later. The only indication that Mr Adams had turned a flap were some almost healed wounds and a bizarre hair style. The perpetrator of the dark deed was apprehended and I was subpoenaed to appear at the Old Bailey but was not needed in the event as a plea of guilty was submitted. There was a lot of villainy in Bermondsey at that time and I was subpoenaed three times in as many months but never had to appear as it happens.

'Ash cash'

Was it Miss Knight in the Registrar's Office? If it was, then she was the scourge of all those who hadn't filled in their death certificates properly and woe betide anyone who hadn't answered all the questions on the cremation forms adequately. Crem fees were three pounds a time in those days and we regarded it affectionately as 'Ash Cash'. There wasn't a lot of 'Ash Cash' about in those days but we were always very pleased to get it. Three quid at that time was a tidy sum. The hardest thing to do was to ask relatives permission to do a post-mortem. The pressure on us to get these things done was very firm in certain instances and it could be distressing business getting distraught relatives to agree to it. I always got the permission but wondered at what it was in me that insisted on it and why I did not rebel at the thought of what I had to do to get their agreement. However, it didn't do to think too hard about the why and wherefore. One 'flew' by the seat one one's pants and if one wasn't a 'stick and rudder' man then one could fall out of the sky. In the case of the post-operative deaths, the Coroner's Officer had to be involved and many was the time I watched hapless cardio-thoracic SHOs hauled over the coals by the Coroner's Pathologist. If ever there was psychological abuse, then it was on these occasions. One may have been traumatized by the death of a patient but to have insult added to injury did little to further the cause of medicine in my opinion.

In the three months I spent at the Breast Unit only one patient died which was a surprise to me and a tribute to the direction the treatment of breast cancer

was taking. The advanced cases stayed on the ground floor and were treated according to a very precise regime which Mr Hayward applied with great success. The first registrar there was David Tong and when he left, David Klugham took over.

I shall remember those Tuesday evenings when I used to clerk in at least 10 patients. The ward was curtained off round each bed and I tried to keep my voice down as everyone was so quiet and probably very frightened. In the background there was the sound of thousands of voices cheering on the Millwall Football Club. Apart from taking a history, I had to demonstrate the lump and draw an X-marks-the-spot cross with a black felt tip pen. Of all the de-personalising things I ever had to do this was the one which bothered me the most because it wrested a vital and emotionally central part of a woman's anatomy from her to us and became our property for the duration. We only gave it back to her on those dreaded but necessary Friday morning rounds—or took it away the following Monday afternoon.

IV alcohol as an analgesic

There was an interesting trial with regard to the use of intravenous alcohol as a pain killer in the post-operative phase. A hundred millilitres of absolute alcohol would be added to a litre bag of dextrose saline and then run in over the next 12 hours. All the alcohol had to be accounted for and never was a hospital pharmacist more edgy than in the proper accounting for these rather handy little bottles which could have so easily disappeared into a bowl of punch and made a truly lethal concoction. I was so impressed with the stuff that when I landed up as an SHO at Farnborough Hospital, Kent, I tried it out several times as an alternative to opiates. But here again, the hospital pharmacist became very concerned about me every time I ordered a bottle of 100% alcohol and due account had to be given as to the indications that had prompted its use.

I learnt my first Cockney rhyming slang at New Cross from a lady with a fungating carcinoma of the breast which had reached such monumental proportions that her entire breast had been involved and the smell once the dressing was removed would have had the vultures revolving in the sky above the hospital in another time and place.

'How are you today?' I'd ask.

'Same old two and eight.' she'd reply.

I have used a lot of rhyming slang over the years for in it are some of the great euphemisms of the English tongue. When giving directions to a surgeon about to go on a visit to something that is festering away, I'll say:

'You can't miss it, it's the house with the vulture sitting on the chimney pot!'

On 19 October 1970, Jacqui and I announced our engagement in the *Daily Telegraph*. My capital had not amounted to much and I had had plans for buying a Hammond Electric Organ, but a trip to Hatton Garden and the purchasing of a solitaire diamond engagement ring put paid to that. It was a heady time and I had put in for the Mann/Scott/Clark house job as my first choice. This time, I got my wish and the thought that I had another six months at Guy's filled me with expectation. No longer was I Treasurer of the Residents but I had not bargained for the Resident's Play which would follow in February 1971. More of that next time.

J H Pitt-Payne

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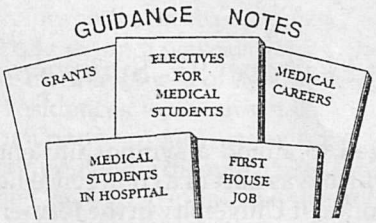

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Dreite Europäische Studentkonference Der Charité

Including the 'Medical Study and Europe '93' Symposium

Two members of SMEC were invited to attend a symposium entitled 'Medical Study and Europe '93', which was part of a conference held at the Chartié Hospital (part of the Humbolt University in the former East Berlin). The two most senior members of SMEC, Omar Rahim and Edward Mckintosh attended, with Omar presenting the ASME prize winning paper 'Does the presence of students in hospital clinics disrupt doctor-patient communication?'. Five abstracts from BSc students at UMDS were also entered for the Zondek Prize, which was advertised at both Guy's and St Thomas's campuses but unfortunately, none were picked as winners. There were surprisingly few students from England, St Mary's and St George's being the only others to attend, in addition to a houseman from Southampton. This was part of a truly European gathering from Austria, Belgium, Bulgaria, France, Hungary, Italy, Lithuania, Macedonia, Netherlands, Norway, Portugal, Romania, Russia, Spain, Turkey and of course, Germany.

The conference took place from 15-17 October. It has been run by the hospital for many years to provide a chance for its own medical students to present the results of research which they have undertaken. It is only since the disappearance of the Berlin Wall, however, that the hospital has been able to invite foreign medical students to attend.

The papers were presented during one of nine plenary sessions, running from 8.30am to 7pm on the first two days, and ending just after lunch on Saturday. Sessions covered the following topics: surgery, gastroenterology and oncology, immunology/molecular biology, cardiology, two neurology sessions, presentations for the Robert Koch Prize (open only to students at the college), a free medical topic and the medical education symposium at which we were asked to present.

Those presenting were meant to stand beside posters summarising their research in between seminars in order to promote discussion. During the sessions there was Imbiß (coffee and snacks).

Food was great, including a lunch served in a magnificent café which must presumably have been the haunt of party bosses and high-ranking Stassi officers. Evening meals were similarly organised, starting with a welcome party in the 'Medclub' on the first night and with a *Berliner Abend* (pig roast) on the second night.

Accommodation was provided in the flats of medical students studying at the college, and was generally comfortable (though some students found themselves in blocks of flats sharing lavatories and showering in the kitchen). The residences were universally distant from the medical school, requiring about a one hour journey by tram and train. On the whole this didn't matter, but coming home through crowds of neo-Nazis was an interesting experience.

The Charité Hospital was the main hospital for East Germany and as such is very modern and well equipped. The standard of research being presented was certainly equal, if not superior to our BSc projects, although the presentations themselves were generally lacklustre, even allowing for the language gap, as this was the first chance that the German students had had to present anything.

The problems and solutions in medical education and employment in the countries represented were discussed in the medical education seminar. From an English point of view it appeared that medical education in northern Europe is much more theoretical and far less practical than ours, with it being possible to qualify in the former West Germany almost without having clerked a patient. What was more of a surprise were the vast levels of unemployment for doctors in almost all European countries (35,000 unemployed in Italy, 1,500 in Berlin alone). This may largely be due to the fact that Britain is one of the few European countries to limit entry to medical school by competitive exams and obviously this has the implication that once the single European market really comes into effect the current trickle of European doctors coming to work in England could increase dramatically.

Another major topic of discussion was the ECTS scheme by which students training at participating medical schools use a system which gives credits for each unit of the course studied and therefore allows students to swap medical schools during their study, possibly several times. This scheme is still in its infancy but a French medical student present had spent a pre-clinical year studying in Dublin and we were introduced to students from Switzerland and Hungary who were spending time studying at the Charité.

Overall the conference was very interesting both scientifically and culturally and we were very well looked after both by the hospital and by our hosts. The only depressing impression that we have taken away is the feeling that UMDS could be rather left behind as Europe and European medical schools become more integrated (especially with the appalling language skills shown by British medical students compared to other European students). This was further confirmed when I found myself on the plane home sitting next to a German doctor on his way back to his house job in Dundee.

The organisers intend to have a similar conference next year but hope that it will be bigger still. If this increase in size follows the trend set over three years since the disappearance of the Berlin Wall, next year's conference will be overbooked and advance warning was given that in this event students would be invited to attend based solely on the merit and quality of the abstracts submitted. Anyone interested in attending next year should contact the SMEC Chairman at Guy's ext 4870.

Omar Rahim and Edward Mckintosh

"Quote-Unquote"

Passing a chemist's while on a shopping trip for the morning's cooking 'therapy' session, a convalescing manic depressive patient asked of his carer:

'Mind if I pop in?'

'Alright, why?'

'I just wanted to buy a 100 paracetamol,' he said nonchalantly!

'That was *not* funny,' she replied.

Guy's Hospital

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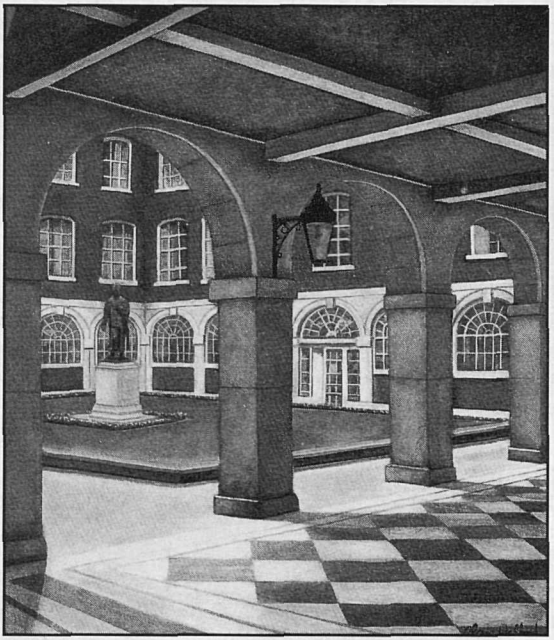

These high quality cards depicting the Colonnade are left blank inside for your own message. The original oil painting by Clare Walford, a recent graduate, was presented to Dr Scott in appreciation of his 20 years as Gazette Committee Chairman. Cards are available in packs of 10.

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407 Art Club

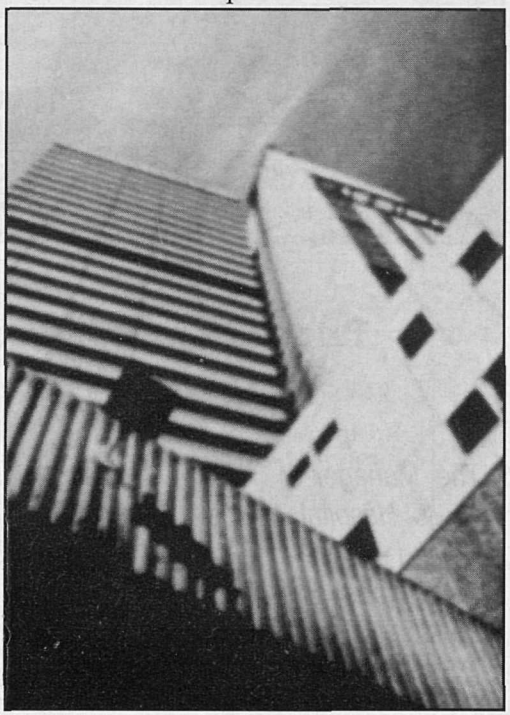
The Christmas exhibition

The 407 Art Club held its Christmas exhibition on the theme of 'Southwark' in the Studio on the 4th floor of Hunt's House. The artists, all with different associations to the hospital, each had a unique style and a different interpretation of the theme. A wide variety of media was used, including watercolour, oils, pen and ink drawings, and photographs.

The interest for me lay in the artists' perceptions of the subjects, ranging from the dramatic black and white photographs taken by G Mulcahy, who successfully captured the play of light and shade on the gritty buildings of the Guy's site, to the exhibits by M Adinolfi which encapsulated the distinctive character of the London Bridge area.

Not only was the present represented, but also the past in the form of photographs from Liam Kearny which provide us with a glimpse of an important historic record of this changing landscape. A landscape of a far more idyllic sort was depicted by one of the exhibitors who painted a vibrant and rich panorama of unspoilt beauty, a place of solitude—perhaps Southwark in days long gone by; one can only dream.

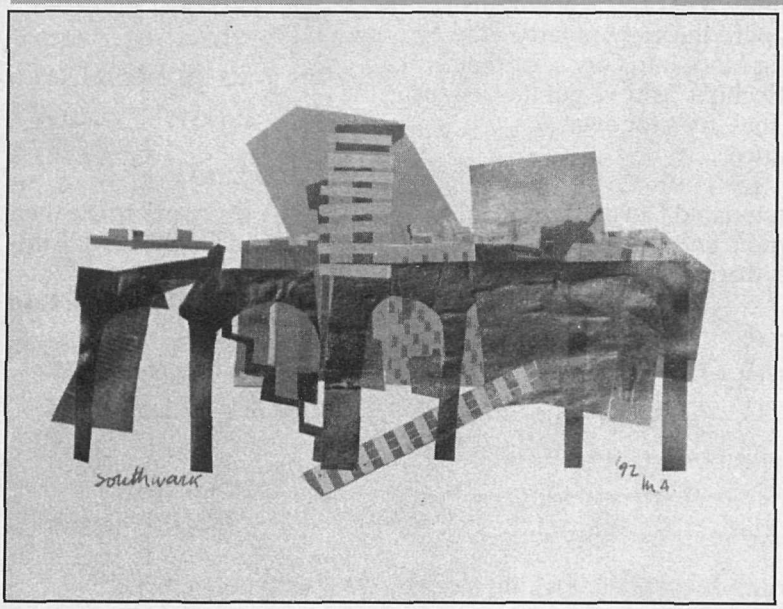
Mohjir Baloch



Guy's Tower captured by G Mulcahy

Photos: M Baloch and M Flanders

Liam Kearny's photograph depicting Borough High Street as seen in 1967



An unusual composition by Professor Adinolfi, depicting some of the constituents that go to make up Southwark.

'You've got it!'

Changes at Guy's

Now that sterile old age creeps
Beneath the sheets of obituary columns.
In bed problems of prostatic leaks,
With the polystyrene creaks of mattress covers.
I shout out in remembrance of youth.
The good old days at Guy's, no female peeps
On ward rounds of the male élite.
No female doctor's training courses then, but of course,
Now a female's signature, with a wet ink source,
Could end all joy at Guy's and dispense,
Its utter existence. But hang on a bit,
Trust 'Status', the cunning old sod, has watched Jimmy's
Lit on the telly. That aortic aneurism
Laid bare, with the scent of fatty fried eggs on air,
He's got Big Macs into Guy's, cardiac brace,
Triple, with chips. You've got it—just taste
The work for Guy's for ever.
Pass the sauce.

This Recessionated Devon Bard would like to dedicate this work to the then Doc Hazlewood and all those that passed through 5 Sandrock Road, Tunbridge Wells, during the '39 war.

Bruce Wotton

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Medicine cases

100 Cases for Students of Medicine. 2nd edition. M D G Gillmer, D Gordon, P Sever, P Steer. Published by Churchill Livingstone. Price £9.50

This is the second edition, 12 years on, of this collection of clinical case histories. There are 15 broadly surgical, 30 obstetrics and gynaecology and 55 medical. There has been a general update of the cases and some new material since the first edition. Consequently AIDS has become an important consideration; and one patient was forced to leave Kuwait during the Iraqi invasion. One of the current patients is the daughter of a Yorkshire pit deputy so it is quite likely that further changes will be needed in any new edition.

These cases are nothing like the case conferences of journals such as the *New England Journal of Medicine*. The case studies are concise and the pointers to the diagnosis come from the history and examination findings rather than the investigations which are not too extensive. The discussions of the cases are kept fairly brief too, with clear clinical points but no attempt to go further back into the basic science. The random order of the cases means that they are most useful to quite senior students with a reasonably broad clinical knowledge.

They are not so suitable for a real problem-solving approach. The book makes interesting browsing material and will bring up points which need further exploration in other texts. This case study format should be better suited to computer aided learning where possibilities can be explored rather than just turning the page to get the answer, but we have not yet reached the era where all medical students have a personal computer in the pocket of their white coats.

Some of the histories will be quite testing for medical students but they are fair and will provide an enjoyable form of learning. The best way of learning is to see patients on the wards, in outpatients and surgeries, and then explore the problems of real patients. When all the real patients have been sorted out then this small volume will provide some suitable additional material.

P J Rees
Consultant Physician and
Senior Lecturer in Medicine

Gynae

Gynaecology—a colour guide. J Rymer, A N J Fish and M Chapman. Published by Churchill Livingstone. Price £7.95

This very attractive book is a new addition to a series covering a range of medical topics. The authors are from Guy's and the Royal London Hospital.

Its text is brief, taking up only half of the 122 pages, and therefore does not claim to be comprehensive, or a substitute for any text book. It is very clearly set out, covering most of the essential points that I found usually discussed during ward rounds, clinics and teaching sessions. As the book has recently been written its content appears to be very up to date with mention of things such as DEXA scanners and mifepristone (RU486).

The other half of the book consists of 147 first class photographs and illustrations. These include some very impressive photographs such as a laparoscopic view of perihepatic adhesions found in

Fitz-Hugh-Kurtis syndrome. The photographs make the book a winner, fitting easily into the text rather than just being added on. It makes interesting reading for any undergraduate, as well as for many doctors.

The dimensions of the book are such (125 x 185 x 6mm) that it is easily white coat pocketable. This allows it to be glanced through in those spare moments throughout the clinical students' day. This book is to be highly recommended to any student starting their obstetrics and gynaecology quartile, and provides a very interesting introduction to the subject. The layout of the text (with subheadings such as definition, aetiology, pathology and clinical features), and its concentration on the essential facts also makes this a useful review book for those about to sit their final examinations.

S Banerjee
2nd Year Clinical Student

Nurses and euthanasia

Nurses are often instrumental in the death of a patient who is terminally ill. But it is often stated as if only doctors decide about the final demise of such a patient. This is what euthanasia is about: a gentle and easy death for those with an incurable and painful disease. Voluntary euthanasia involves the patient making a living will before this eventuality arrives.

Since nurses have been quoted on various sides of the argument it may be worthwhile to look at situations in which they find themselves. In any conversation about euthanasia with nurses, many will refer to occasions when they have been an accessory, through the administration of drugs or withholding of treatment likely to lead to a speedy death. In most of these situations both they and the doctor may have acted illegally if the strict letter of the law had been invoked. In most instances the law turns a blind eye. But this is not voluntary euthanasia whatever blessed relief it may provide to the satisfaction—although they may be unaware of it—of the patient, but perhaps more obviously to the relatives.

It is only when legislation, to protect those who are already practising euthanasia, is suggested that one hears the voice of criticism and protest. Nurses may have their own view, in common with doctors and patients, about life being sacred, or the sanctity of life itself. But whatever belief or view one holds, it should not conflict with those of another.

This is central to our code of ethics. It is only when this opinion conflicts with another's that debate arises.

Moreover, although the notion that each has a right to his own view of life may be accepted, there are those who wish to impose their attitudes and values upon others to prevent a change of law favouring voluntary euthanasia. Some nurses working in hospices claim there is no call for voluntary euthanasia; this is rather like saying there is no call for steaks in a vegetarian restaurant.

Nurses are not unique in this, and it is not confined to a particular life stance. The late Rev Dr Leslie Weatherhead, who was Minister at the Methodist City Temple stated: 'I sincerely believe that those who come after us will wonder why on earth we keep a human being alive against his own will, when all the dignity, beauty and meaning of life has vanished; when any gain to anyone was clearly impossible, and when we should have been punished by the State if we had kept an animal alive in similar physical conditions'.

Nurses may be unique though, in that they play a vital role at the time of death, whether it be 'natural' or by 'voluntary euthanasia'. Nurses need guidance, and it may be that like assisting at abortion, there will be need to be an opt out clause for those whose conscience would not allow them to participate in voluntary euthanasia.

There are a lot of comments about the position of doctors at the bedside of a terminally ill patient, but this often ignores the person who may be closest and spends more time with dying patients. In the hospital this will probably be a nurse, while if the patient is at home this will be shared with a caring relative or friend. Both nurses and such carers have frequently been quoted on the suffering this lingering process may involve, and the sense of relief felt all round when death intervenes.

Cases where problems have arisen, call for a change in law so that the choice may be made by the patient, and the doctor, in line with carers, who can apply that choice. There is no coercion for either patients or nurses in this policy. It is simply demanding that others do not force their views—no one is compelling anyone to die, or participate in unwilling death. It is legitimizing and providing safety to practice that which already happens. The poet Shelley urged us to treat death not as an enemy but as a friend:

If I must die,
I will encounter darkness as a bride,
And hug it in my arms.

Denis Cobell

Screen printing

The Clubs' Union has its own screen printing facilities, which provided sterling service for the rag week T-shirts amongst other things. Fresh blood is now needed (no, not for the ink!) to administer this facility. A 2nd/3rd/BSc medical or dental student would all be ideal. There is no requirement to be creative or artistic—just responsible; hopefully that isn't too much to ask! All those interested should contact Heidi Miller via the notice board between the Clubs' Union shop and the pigeon holes.

Diwali show

The International Society presented the annual Diwali show in November last year. The show was very entertaining in parts and generally well put together, particularly given that the show was organised at the last minute. However, they managed to put together an evening with all the ingredients of previous shows: songs, comedy sketches, classical dancing and a fashion show.

The highlights of the evening were the Curry Crew's comedy sketches and the classical dancing. The spoof adverts and the 007 play were witty, hilarious in places and full of original jokes which struck a familiar chord with many of the audience. The make-up and costume 'departments' also deserve a special mention, portraying reality bordering on farce—a true delight to watch.

The classical dancers were a welcome change to the modernism of the rest of the show. Included were a couple of London Award winners and it was not hard to see why—they displayed great skill and grace and had the audience mesmerised.

There was singing too, of Western and Asian popular songs. Unfortunately the potential brilliance of the group singing the Western songs was blunted by technical problems with the sound system—something which unfortunately plagued the whole show. Not surprisingly, this annoyed both performers and audience alike.

As always, the evening ended with a fashion show. This had a well rehearsed routine with colourful clothes modelled to a great soundtrack. Food, which also catered for vegetarians, was laid on at Boland House.

However, the evening was not without its faults. Firstly the two hour delay before the start of the show was excessive, even by Asian 'etiquette' which can, at a stretch, allow up to one hours grace. With rumours circulating that 300 tickets had been sold for 200 seats, many people arrived early and had to wait outside in the cold and rain. No explanation was offered by the organisers to those waiting, and not surprisingly, tempers flared.

The much delayed start resulted in the after-dinner hop being shortened to just one hour, and the bar was closed, leaving a lot of thirsty and frustrated people. Secondly it was unfair to sell tickets for the Harris balcony at the same price as the rest of the theatre since it only allowed for a very restricted view and the audience ended up having to stand for the whole show. Also, although this was a 'Diwali' show, named after the Hindu Festival of Light, many people were saddened not to hear a single mention of Diwali itself, or its meaning. Finally, the compering, or at least part of it, left a lot to be desired. It

was generally rather abusive and lacked eloquence and humour.

Overall though, the evening was an entertaining one. It was a shame that the core of excellent material was offset by technical faults and organisational inadequacies; perhaps one person cannot run the show alone. Nevertheless, thanks and congratulations must go to all those involved.

Shahid Khan and Smita Patel

Rugby: 1st XV

Guy's 1st XV v Old Walcountians.
24 Oct. Won 45-11.

There were a number of factors that made this game very important to Guy's. Firstly, we had lost the first three league games of the season, all of which had been there begging to be won, and secondly, it was one week after the tragic deaths of James Hawker and Alex Boulger. A number of the 1st XV expressed their concern about playing such a vital match so soon after the accident, thinking that it might have an adverse effect on the team. However, we were all shown a great deal of courage by the families of James and Alex, and eventually it was decided that we should play the game. 'Anyway, we're not going to lose!' challenged Prof Challacombe.

There wasn't much need for a team talk for the 1st and 2nd teams (both games were at Honour Oak Park); the one minute's silence was all that was required for the players to focus on the next 80.

Apparently both teams came out from the kickoff with a great deal of passion which rocked Old W's, and playing in the first team, I was jubilant as Richard Docker scored within five minutes of the start, and ignorant of the fact that the 2nd team had done exactly that at the same time. Relentless pressure from the Guy's 1st XV produced two more unconverted tries from Breeze and Ryan taking the tally to 17-0.

A strike against the head for Guy's on Old W's line gave Challacombe at No 8 a well-coordinated pushover try. 25–0.

From here, Guy's play began to slow allowing old W's back into the game with a couple of penalties to bring the half-time score to 25-6.

The second half fared no better for Guy's or Old W's, due to a timely 15 minute hailstorm. This limited both sides scoring to absolutely nothing, but when the clouds broke, Guy's became inspired once more. Matt Rose scored a very determined try from slick handling in the backs and Docker, creating a bit of a prob-

lem for their scrum-half, capitalized on an untidy pick up and pounced for 7 points. Llewellyn's earlier penalty had helped to lift the scoreline to 40-6.

Old W's produced a consolation 5 points but the best was reserved for the now spectating 2nd XVs. A tapped ball from a lineout in the Guy's 22 was cleared by Challacombe who made 15 yards before passing to Llewellyn, again making some good yardage. Worth took the pop-pass at full tilt and headed for the posts. Inside their 22, he threw out a pass to Docker who linked with Davies to score a beautifully worked try. 45-11

A deserved victory that the players demanded of themselves and ultimately dedicated to James and Alex.

Guy's 1st XV v Alton. 31 October. Won 22-20.

We received a taste of our own medicine when Alton scored the first try of the game within 5 minutes of the start. However, a strange thing took place—we stood there and looked at each other thinking: 'So what! We're still going to win'. Now there's confidence for you! Guy's immediately took the game to Alton and scored a pushover try through 'Billy' Challacombe, which was converted by Neil Davies. This set the tone for the game in the scrums, which Guy's dominated through a very solid performance by the front row of George Tsolakides, Ben Stanhope and Mike Seare, and despite the winning Guy's scoreline they will probably remember taking three against the head.

The lineouts were more fiercely contested and with their superior weight and height Alton dominated their throw-in, scoring a well-worked maul from five yards off the Guy's try line. The scoreline at half-time was 12-7 in favour of the home team. But don't forget the confidence.

At the restart Guy's swarmed over Alton from a poor pass and the ensuing ruck, having sucked in both forwards and backs, created a lovely sight of a three-man overlap, which Pat Gush finished off quite nicely. 12-14.

Guy's began to dominate most areas of play and this was converted into a further 8 points from a Neil Davies penalty and a lovely worked try by Richard Breeze. A scrappy tail-end of the lineout ball was cleared up by Beardmore who fed the oncoming Jeremy Worth, going at his full awe-inspiring, 16 stone pace. He stayed up on his feet from the 22 to the tryline, laden with tacklers, Llewellyn (captain) secured the ball, fed out to Raj, whose quick hands and quick thinking delivered the try-scoring to an already diving Breeze. 22-12.

Alton began to get fired up as they saw two league points begin to slip. To their credit, they came back hard with unremitting pressure against which Guy's defended well. A penalty narrowed the margin to 7 points and Alton began hunting for the converted try to snatch a draw. They ran everything from everywhere, and Guy's countered with determined and, at one point, bone-cracking tackling; Worth's tackle on their hooker looked, sounded and most definitely felt painful. Indeed, the hooker was stretchered and Jez's left arm was numb for five minutes.

Alton continued the onslaught. Quick tap penalties, rolling mauls and aggressive running worried Guy's defence, but didn't breach it. Then, with seconds remaining, Guy's had a final perfect scrum.

But Altons scrum-half managed to disrupt the clearing pass that would have ended the game. Instead, they cleared up the loose ball and scored a last ditch try. The kick was the last play of the game and I've never been so grateful when their flyhalf missed. Guy's were lucky to get two points but we felt we deserved them.

Guy's 1st XV v Eastleigh RFC. 14 Nov Won 20-7.

The Honour Oak Park ground was a touch heavy and the weather was not conducive to a game of running (Guy's style) rugby. From the start Eastleigh were going to be difficult opponents to play against. They dominated the full lineouts (Guy's countered with well worked shortened lines) and out-mauled the smaller Guy's pack but Guy's countered with a dominant scrum. Unfortunately, first blood was drawn by Eastleigh with an interception try. Close, so close, to being a Guy's try at the other end. Guy's attacked well before half-time but could only manage a penalty.

Guy's emerged at the restart with a touch more vigour and this was certainly reflected in Jones try. A solid scrum produced sound ball for the backs who passed accurately for Baker to burst through two tackles and link with Breeze who in turn passed back inside for Jones to finish off a sweet little move. Very slick.

From this point Guy's didn't look like losing but they were making heavy weather of their rucking game by not arriving in effective numbers. However, Breeze polished off a good all round performance with a great show of slightly muddied heels to take the final score to a well earnt 20-7.

Rugby: 4th XV

Guy's 4th XV v Hammersmith & Fulham. 7 November. Lost 14-15.

The 4ths came within three minutes of victory in this exciting game. In a tight first half, Guy's matched their opponents in the forwards and possibly had the edge in the backs, but the Hammersmith took the lead when they pounced on a handling error to score a try.

After half-time Guy's took the lead after Chan scored in the corner after some good handling by the backs. Hammersmith regained the lead with their own converted try.

However the 4ths showed great spirit to recapture the lead with what looked like a winning try by Mark Lewis, until a penalty for offside at a ruck gave the opposition the game.

Team: Lutz, Russell, Howell, Blunden, Henessy, Lams, Holmes, Miles, Mike Lewis, Mark Lewis, Hawker, Osbourne (rep Coombes), M Chan, Jim.

M Blunden

Guy's 4th XV v Warlingham. 14 Nov Won 31-17.

Despite the opposition having an extra man, this was a truly memorable and eventful day for the 4ths. Warlingham opened the scoring with a try and conversion after Guy's missed a number of tackles. Guy's came back well to equalize through Ekeowa, but gave the lead away again to a Warlingham try.

After half-time Guy's equalized through a long range solo effort from Ekeowa and took a 17-12 lead with an Underwood try. With less than 10 minutes left, Warlingham came back, but Guy's raised their game with Ekeowa completing his

hat-trick and Blunden scoring a short range effort to seal victory.

Team: Lutz, Lams, Howell, Blunden, Rose, Eddy, Marshall, Underwood, Singh, Quick, Osbourne, Ekeowa.

M Blunden

Guy's Hospital Boat Club

Boston Marathon

The new season began with a trip to compete in the world's longest rowing race, the Boston Marathon—a 31-mile time trial held every September between Lincoln and Boston and a regular event in Guy's calendar since 1967. The first ever Marathon report in the Gazette described the race as an 'exercise in masochism' and all the hundreds of Guy's oarsmen and women who have subsequently competed can personally testify that nothing has changed. And yet every year despite protestations of 'never again' the year before, Guy's has no difficulty in fielding crews for this ultimate test of endurance. This year was no exception.

For the first time ever, Guy's entered three VIIIs giving it the largest club entry in the event and providing us with the nightmare of transporting over 30 people and nine boats (six of which belonged to other clubs) 200 miles to Lincolnshire and back. Late Saturday morning saw 'Technical Director' Dicky Simons at the wheel of a specially hired minibus leading a convoy out of the boathouse car park heading for our traditional Saturday night hosts, Fred Moorehouse (Captain 1972-73) and his wife. As usual, their hospitality was superb and extremely efficient, managing to serve breakfast to all within 45 minutes on Sunday morning in preparation for the planned 8am departure to Lincoln.

Whilst the boats were unloaded at the start, the support team set to work transporting cars and belongings to the finish. First on the water was the ladies 1st VIII, competing in their brand new boat *Thomas Guy* for the first time. That was the last the men saw of the ladies before the finish as they were far too swift to be overtaken, finishing in 4 hours 40 minutes and slashing 30 minutes off last year's time.

The men's 2nd VIII were next, rowing for the first time since the end of the Summer term and in their first Marathon. A gutsy row over an unfamiliar course rewarded them with a very creditable time, a shade faster the ladies' 1st VIII.

The men's 1st VIII boated last with a virtually scratch line-up and only a couple of pre-event practices. Rowing in our new men's boat *Michael Gleeson* and coxed by Fred Moorehouse, the crew set off at a blistering pace reaching Bardney Lock in 48 minutes—four minutes ahead of schedule for a sub-three and a half hour marathon! This pace was maintained for another 90 minutes during which a long battle was fought with the 2nd VIII. Then as the course became less protected from the now very strong head wind and the excesses of the night before took their toll, the pace began to drop. After half an hour's 'encouragement' from Fred, the crew began to work together again and made easy work of the last few miles finishing under the gaze of TV news cameras to the cheers of the large assembled crowd. The time was 3 hours 47 minutes on a day when only 15 crews made the finish in under four hours. The time was good enough to give Guy's the second

place in the VIIIs class, the highest place of any college competitor and fifth place overall out of over 130 entrants.

Thanks must go this year's committee and Alex Cash who did so much to make the weekend successful and, in particular, our non-rowing support team of Dicky Simons, Kate Scanlan, Ed O'Toole, Fee and Chrissy.

Freshers' Week events

It has always been our tradition to encourage as many freshers as possible to take up rowing or coxing no matter what their background or previous experience. With the Club's continued independent existence in doubt and with it, freshers' rowing opportunities, Guy's set out to give the freshers a welcome to UMDS they would never forget.

On their first day in residence, every new medical and dental student was given a personal welcome letter and an invitation to a free drinks reception in Boland House that night. Over 200 attended giving them the first opportunity to meet their friends for the next five years. Thanks to social secretaries, Ruth O'Sullivan and Ed Lawson, the drink flowed freely, a theme which we were to follow during the whole of Freshers' Week. At the Freshers' Fair, two days later, the Guy's stand was serving Pimms' as Club members handed everyone interested a copy of our freshers' brochure, a masterpiece of graphic design by Vice-Captain John Paul Carpenter. Over the next week, three beginners' introductory sessions were held at the boathouse during which over 80 freshers made their way to Chiswick to try out what we had to offer. This task was made far easier by the excellent refurbishment of our veteran eights *Frank W Law* and *Tunny II* over the Summer by Dicky Simons.

On the last Saturday of Freshers' Week we held a barbecue at the boathouse which was attended by considerably more freshers than those at a similar event hosted contemporaneously by all the other hospital boat clubs put together. With all (but two!) of the UMDS freshers choosing to row with us this year, we were able to select four fresher novice VIIIs, bringing the total club membership to over 90 for the first time ever. We were particularly lucky to recruit five new members with a genuine talent for coxing and with 10 crews (including eight VIIIs) taking to the water, the seeds were sown for the considerable success which was to follow.

United Hospitals' Boat Club AGM

The Annual General Meeting of UHBC was held in late October and resulted in Guy's being elected to run UHBC for the coming year. Jonathan Robin was appointed Captain—Louise Ward and John Paul Carpenter, Vice-Captains—Neil Harrison, Secretary—and Andrew Hobkirk, Treasurer.

Congratulations

Congratulations must go Guy's member Tim Webber who has recently been selected for the Great Britain under-23 squad.

Janousek Fours Head

The first race of the new term was the Janousek Fours Head (formerly the Watney Fours). Despite the event being far larger this year, Guy's maintained its excellent record. With entries being limited in number to two due to a shortage of fours, the ladies' 1st IV (stroked by their

Captain Louise Ward) won its division convincingly, and a scratch men's 1st IV came second to beat all university crews in its class.

The Allom Cup

Run under the auspices of ULBC and open to crews from all London University constituent colleges, the Allom Cup was held on Sunday 22 November with Guy's having by far the largest club entry. It was the first opportunity for our two men's and two ladies' novice VIIIs to show their considerable talent. With two equally matched novice crews in each category, it had been possible throughout the term to provide regular side-by-side race practice (much to the interest of visitors to Kew on Saturday afternoons), a benefit not enjoyed by any other college.

The mens' novice A crew devastated the opposition on its way to the final amid protests from other competitors that they were too good to row as novices. Even the chief coach of ULBC had to admit they were the best novice crew he had ever seen. The novice B crew (who in practice often had the edge over the A crew) were narrowly defeated in the semi-final by a crew from Royal Free who were definitely not novice and who presumably had been fielded to prevent a Guy's v Guy's final. Our protests, perhaps not surprisingly under the circumstances, fell on deaf ears, but the honour of the Club was restored by the A crew in an effortless three length win in the final over University College and a *bona fide* Royal Free novice crew.

Not even four Californians rowing for the London School of Economics could stop the men's novice IVs final being held between two Guy's crews with a IV drawn from the novice B VIII ultimately prevailing.

The event was marred by sudden timetable changes which hindered our ladies' novice VIIIs but a novice IV drawn from their number came second in its class.

The senior crews also did well. The men's 1st VIII stormed to victory in the Junior VIIIs. Two key members being stuck in Tunbridge Wells and a lost blade off the start, prevented the possibility of this success being repeated in the Senior VIIIs. Credit must also go to the men's 2nd VIII who also easily reached the final of the Junior VIIIs prevailing over strong opposition in the semi-final with a 40 stroke per minute sprint of which any first crew would have been proud. The ladies' 1st IV cruised to an easy victory as expected leaving it to the ladies' 1st VIII to have the most spectacular race of the day winning in the final against St Thomas's by two feet.

With five wins, Guy's crews were the most successful in the University, our nearest competitor being University College with its far greater personnel resources. The only other hospital to win was the London with success in two events.

The United Hospitals Annual Winter Regatta

This event was held a week after the Allom Cup and was organised by Guy's. A total of 97 crews competed making it probably the largest UH or UL regatta ever, with again Guy's fielding the largest entry. Right from the first race of the day—an easy three length victory in men's junior IVs over St Thomas's—Guy's seemed to be enjoying unparalleled success. By the end of the day there were final wins for Tim Webber and Ruth

Selwood (in the men's and ladies' open singles respectively), the men's 1st VIII, the men's novice A VIII, a IV drawn from the men's novice B VIII, the ladies' 1st VIII (this time thrashing St Thomas's), the ladies' 1st IV, the ladies' novice A VIII, the ladies' novice A IV, the 1st mixed VIII and the novice mixed VIII.

The men's 2nd VIII (superbly organised all term by Steve Arnold), despite having a raw deal as result of the regatta organisation, also reached their final outclassing all other second crews, as did the ladies' 2nd VIII. Andrew Hobkirk was also very unlucky to lose in the final of the mens' novice sculls after knocking out the St Thomas's Captain in the semi-final.

With 11 wins out of 13 events entered and with finalists in every one, Guy's easily won the newly inaugurated victor ludorum trophy—'The Stedman's Challenge Cup' presented by medical publishers Williams & Wilkins Limited, UHBC's new sponsors and originators of (inter alia) the Stedman's Medical Directory. The Cup was received on behalf of the Club by last year's Captain Alex Cash. The sponsors also kindly provided copies of their excellent dictionary to be presented to the winning novice crews, which all of course went to Guy's. Once again our nearest rivals were University College & Middlesex and the London with three wins each. The only other hospital to win was our good friend Barts with a well-deserved victory in the men's IVs.

Despite the huge size of the event, the Regatta (for almost the first time ever) ended complete on the same day, albeit just as dusk was beginning to fall. Thanks must go to all those who helped to make the event so successful, including the UHBC committee, the men's and ladies' 2nd VIIIs and, in particular, umpires—Michael Gleeson, Chris Harris, Danny Painter, and Rob Pinckney, and non-rowing volunteers—Michael Rocker, Charlie Sherwin, Dicky Simons and Henry Carlton.

Jonathan Robin
Captain, Guy's Hospital Boat Club

UMDS Ladies' football

Within three minutes of the opening whistle UMDS were on top, the first goal of the season! Rising confidence of the forwards and a solid defence gave UMDS Ladies their first victory, 12-0 against Bart's, with weekly practises and the team's superior fitness obviously paying dividends. A fortnight later with renewed enthusiasm we took on St Mary's lacking two of our key players, Claire Daniels and Yasmin Kapadia. We battled courageously for a 1-1 draw which ended an exhausting but successful game.

The rest of the term held mixed fortunes. A difficult wind and driving rain called off the match against Goldsmith's College after only 25 minutes which was disappointing considering the team were playing an attractive passing game and the forwards, Deepa Mohanan and Naheed Khan, always looked dangerous. We were unlucky to be drawn against KCH, a top first division team, in the first round of the UH cup and went out 0-3. However this was good practise for our goalkeeper Juliette Balakrishnan (also owner of the muddiest tracksuit!). There is a busy forthcoming term with matches every Sunday and a few to catch up with from last year due to weather and pitch

conditions. We're still aiming for promotion to the first division so UL trials and a tour to Liverpool/Preston should keep us on our toes.

As a final note, I'd like to mention that we are always looking for any enthusiastic players who have been too shy to show themselves as yet.

Sarah Brooks

Ladies' football team. From left to right: Wendy, Emma, Sarah, Juliette, Claire, Parry, Deepa, Rashmi (back row), Naheed, Yasmin, Cother, Reena (front row).

Late News—Boland House Lockers

The Fire Brigade requires that the lockers on the first floor of Boland House be moved in order to comply with fire safety regulations. From Monday 1 February, clinical students' lockers will be in the basement of the nurses' home. Please see Terry Mitchell in Medical School Reception at the earliest opportunity in order to be issued with a new locker, and in order to transfer belongings from your old locker.

New Doctors

The following students qualified MB BS (London) in December 1992:

Adams, R E
Allison, Miss H J
Antoniou, A V
Boyle, Miss A
Crookall, P R
Cutts, S
Davies, S J
Dawson, Miss J V
Evans, R G
Gilbody, J S
Gill, Miss J E J
Grace, Miss T E
Huseyin, T S
Jagathesan, R
Lam, K H F
Rahman, Miss S
Schuman, A N
Simmons, Miss J
Walford, Miss C
Walsh, D M
Wynne-Jones, G A

New Dentists

The following students qualified BDS (London) in December 1992:

Ameerally, P J
Anderson, Miss D K
Aquilina, J W
Baker, P S
Bazzaz Ghaffari, Miss E
Boundy, Miss S C R
Brown, A D R
Butcher, M K *
Capewell, I L
Chandarana, S
Clements, Miss S A
Combes, J G *
Cope, Miss C J
Costello, J P
Daniels, Miss S
Dhonsi, S S
Dickson, A C
Downey, J T
Duncan, Miss H E
Earl, T J
Fletcher, Miss L J
Gaminiratne, Miss A N □■
Ghows N M
Givans, B D H
Grace, Miss P M
Gupta, Miss R
Hajatdoost Sani, Miss M
Hasen, H
Higham, Miss K A
House, J C
Jones, D T
Joshi, Miss J S
Kalkat, Miss A K
Kangesu, Miss N
Karunanayake, G A
Kellet, Miss A-M
Khakhar, Miss M
Kochhar, R
Kok, Miss E C
Kumar, S
Liu, M K W
Machell, J R A
Malde, Miss B
Miskry, S P M
Movahedi Najafabadi, Miss S * □■
Nasrallah, Miss B
Ogden, M R
Papandreas, Miss J *
Park, P D
Patel, Miss M S
Pessian Haghighi, Miss F
Pringle, R J S
Purdom, Miss A T
Ress, Miss V J
Reynolds, Miss C L

Rose, M D *
Ruparelia, V A
See, Miss S H
Seth, Miss M
Shah, Miss A J N
Sims, B J
Singh, J
Slipper, Miss C L
Suchak, Miss S K
Syed, Miss M
Tandon, V
Thompson, Miss C L *
Tolputt, Miss S A
Walsh, S J
Willetts, A J

Key
* Honours in Dental Surgery
□ Honours in Orthodontics and Paedodontics
■ Honours in Prosthetic Dentistry

Prize winners

Congratulations to the following on winning prizes in the *Gazette* Christmas raffle. We are very grateful to all those who participated.

1st prize—£250
Prof R D Rubens

2nd prize—£100
Mr M Blake

3rd prize—£50
Mr S Harding

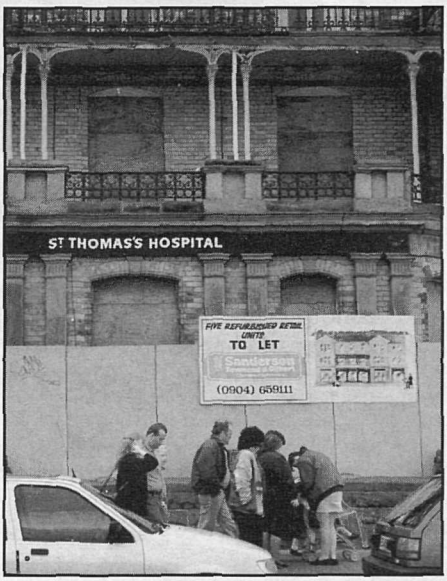
4th prize—£30
Dr N Bouras

5th prize—£20
Mr M Day

Five runners up prizes of £10 each were won by:
Mr R S Crisp
Mr E O James
Dr B Bancilhon
Miss E G Willcocks
Dr B Gethen Smith

Caption competition

Dr Paul Bridges of the Division of Psychiatry is the winner of the caption competition. His prize of £10 is on its way.



Death

WASS, June Mary Vardine, died peacefully on 3 November 1992. Wife of late Mr Sam Wass, she will be greatly missed by her sons John and Bill.

BENNETT, Vic, died on 20 December 1992 aged 74 years. First as lab boy and finally as Chief Technician, he worked in the Physiology Department for 45 years (apart from war service) until his retirement in 1983. He leaves a wife.

Correction

The death notice in the December *Gazette* should have read John Vernon KILBY, not Kirby as printed. Our sincere apologies go to his family and friends for this unfortunate error.

Classifieds and Announcements

The *Gazette* is pleased to publish classified advertisements. These are charged at the rate of 10 pence per word—money with order please. It is helpful if you can include a contact telephone number in case of any queries.

Announcements of births, deaths and changes of address will be published free of charge.

Please ensure that these items reach the *Gazette* office four weeks prior to publication.

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GUY'S

HOSPITAL GAZETTE

March 1993

- Short cases—a 'how to' guide
- EMSA—weekend French course
- Passive Smoking—Science Museum exhibition

Swan Electric Engraving Co

Tho: Guy.

From the painting by Vanderbank the property of the Governors of the Hospital

CONTENTS

46 **Passim**
47 **Letters**—the merger
51 **News**—stand by ops, Tomlinson costs
53 **Survival Guide**—short case tips
58 **'Eurotalk'**—a French weekend
62 **Passive Smoking**—at the Science Museum
66 **Home Again**—Pitt-Payne back at Guy's
73 **Ambulance Duty**—a student view
77 **Obituaries**
79 **Nursing Notes**
80 **Physiotherapy Notes**
81 ***Clubs Union News***—*Bill Francis writes*
83 **Sport**—rugby
87 **Classified and Announcements**

Guy's Gazette

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The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

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Passim

April 1 sees the initiation of the joint Guy's and St Thomas's Trust to be headed by Tim Matthews. This will then be the largest UK Trust and will have the difficult task of producing proposals for the rationalization of clinical services between sites. One of the issues that the Secretary of State for Health, Virginia Bottomley, has specifically asked to be reviewed is the need to have accident and emergency services on both sites.

These proposals are to be ready by Autumn, and once they have been agreed, it is a commonly held belief that the Government would wish the changes to take place swiftly. The time scale for implementing any changes depends, of course, on just how far reaching they turn out to be, but it would be wise, nevertheless, to move with careful deliberation rather than rushing headlong into chaos.

The formation of a joint Trust doesn't automatically require the creation of a new name. Presumably this is a step that will only need to be taken should one of the sites unfortunately have to close. Readers certainly seem to support the canonization of Thomas Guy and favour St Thomas Guy's Hospital as a possible name. A decision has not yet been made, but one hopes that it will avoid treading too heavily on anyone's sensibilities.

April will also be a time when Guy's parts company with Lewisham Hospital which is to become a Trust in its own right. For the purposes of teaching, these changes are unlikely to have much of an impact, but the economics of the internal market may result in changes in referral patterns.

This issue also sees the last of Diana Innocenti's regular physiotherapy bulletins with her retirement on 31 March, for which we wish her well. She has been writing for the *Gazette* since 1988. As yet, a successor to the mantle of Physiotherapy Correspondent has not been found, but it would be a great shame to lose this aspect of the *Gazette's* coverage.

St Thomas Guy's Hospital

Dear Sir,

It seems possible that some dissidents would regard as frivolous the suggestion that the proposed Guy's/St Thomas's complex should be called St Thomas Guy's Hospital. If so, they must be unaware that the founder of Guy's Hospital has been canonised on several occasions. His sanctity was, for example, accepted by Robert Peel, when Prime Minister. Indeed Peel, in writing to Queen Victoria in 1845, took care to describe the Reverend Frederick Dennison Maurice as 'chaplain of St Guy's Hospital'.

Few things can be more certain than the inability of Prime Ministers to speak anything other than the truth and Robert Peel could hardly have had any misapprehensions about who Thomas Guy was. Peel's father's estate and his own constituency were both in Tamworth where Thomas Guy had been Member of Parliament in the previous century. Guy had also built in Tamworth almshouses and the Town Hall in front of which Peel's statue was erected.

Some may, nevertheless, remain incredulous atthe idea that any saint has ever been a Member of Parliament or indeed would have appropriate personal qualities. This is to forget that Thomas More was a Member of Parliament during Henry VII's reign. Though it is true that he was not canonised until well after his execution in 1535, it would be unreasonable to suggest that he lacked saintly qualities before his untimely death.

Those who still retain unworthy doubts about Prime Ministers' dedication to truth and accuracy, or whether Thomas Guy could be both an MP and a saint may perhaps be reassured by the rough honesty of a character who says, in R M Wingent's *The Dean's Dilemma* of 1908:

Well, comes to that, they do say as 'ow 'e built two 'orspitals—Thomas's and St Guy's—that's w'y they calls 'im Thomas Guy.

However, I sincerely hope that no one would use this brilliant summary of the way in which the hospitals were founded, to suggest that this person had as penetrating a grasp of hospital matters as Professor Tomlinson.

Yours faithfully,

R A CAWSON
Department of Surgery
Guy's Hospital

Progenitor hospitals?

Dear Sir,

When I was a student (1953-59) my pen friend in Lyon, who is now a consultant haematologist, was convinced that I was a student at St Guy's Hospital. Can I suggest that the united hospital could be (as he pointed out from his knowledge of church history) named St Vitus's Hospital.

I have always thought it a badge of honour that those whom St Thomas's had discharged as 'crumble' (to use the technical term in use in the 1950s) were the patients for whom Thomas Guy specifically designed his hospital on the other side of St Thomas's Street.

Yours faithfully,

JOHN WALL
Chief Executive
The Medical Defence Union Ltd
3 Devonshire Place
London W1N 2EA

Guy's men

Dear Sir,
For years the enclosed drawings lurked at home. My father, Dr J M H Campbell, then had more contact with pipes than frogs, but of the others only Dr Vertue was a familiar name as I'm now thinking of the 1940s.

I wonder if there is anything more that other *Gazette* readers can add about the others 'glowing' or smoking their way about Guy's.

Yours faithfully,

DONALD CAMPBELL
The Manor House
Combpyne
Axminster
Devon
EX13 6SX

Euthanasia

Dear Sir,
I have read with interest Denis Cobell's Nursing Notes on euthanasia. I think it is most important to consider, with total honesty, the aim and object of one's own actions, as everyone is responsible for his own.

In my book, to relieve pain is good; directly to kill is bad. Means taken to relieve pain are good if genuinely directed to that end, even if as a secondary effect, life may be somewhat shortened.

Enough analgesia to relieve pain is, therefore, morally permissible, but any act which has death as its sole and direct aim is not.

Yours faithfully,

DR BRIAN D JOHNSON
(Guy's 1940)
19 Beechwood Close
Evington
Leicester
LE5 6SY

Last Will and Testament

Dear Sir,
Since my retirement my wife and I spend some time visiting antique fairs in various parts of Yorkshire and Derbyshire. About three months ago we visited one in Doncaster and, while browsing at a bookstall, I came across a slim leather bound volume which I was surprised to find on looking at the fly leaf, was a copy of *The Last Will and Testament of Thomas Guy Esq* together with the relevant Act of Parliament. It further stated that it was printed for the Governors of Guy's Hospital in 1815.

Since I felt that I would never see a copy of this document again, and certainly not in Doncaster, I bought it for £20 and it now has pride of place on my bookshelf.

Pleased though I am to own this book, I would be interested to know why the Governors had copies of the will printed in 1815. I know that there was an outcry in the 1730s over the interpretation of the word 'incurable'; it being felt that the founder's wishes, in this respect, were not being followed. Therefore the Governors had copies of the will printed and distributed in 1732 to show that the terms of the will were being honestly adhered to .

Can any of your readers shed further light on this subject? Was there a further outcry in the early 19th century over interpretation of the will, or what was the reason for this further publication?

Yours faithfully,

DR GEORGE CANTY
(Guy's 1942-49)
21 Bannerdale Road
Sheffield
S7 2DJ

Dr F H Brain

Dear Sir,
The death of Dr F H Brain, intimated in your rightly generous obituary, takes me back to his lectures and practicals (and indeed to those of his colleagues, Drs Ewens and Hazlewood) at Sherwood Park, Tunbridge Wells in the early 1940s. As a medical student with very little learning in organic chemistry, I well recall his lucid enthusiasm, his approach-

ability, kindness, humour and willingness to take pains with us.

For myself, the interest he (and those colleagues) generated in the subject has lasted all my professional life, and for that gift I am continually grateful.

Yours faithfully,

JAMES HUTCHISON
38 Chantry Road
Moseley
Birmingham
B13 8DJ

Do we see but not observe?

Dear Sir,

This fascinating article (*Guy's Gazette*, November 1992) contained much of which I have been convinced for many years. The day of hi-tech has all but eliminated the hands-on, eyes-open approach which medical consultation should embrace.

There is one point on which I must take issue, that is the 'drug company representative with acromegaly who, over a period of five years, saw more than 10,000 physicians'.

Taking into account that there are 1,305 working days in five years (ie 5 x 365 minus weekends), 10,000 physicians in 1,305 days means an average of 7.66 visits per day, five days a week for five years.

Come now! Which pharmaceutical company would allow one of its representatives to spend so much time seeing to his own health? The fact that none of the physicians spotted his problem could be attributed to the fact that he had to be in and out, like mercury in a chicken.

Of course he could have claimed the visits as business calls, in which case he probably received a bonus from his company!

Yours faithfully,

DR F N SANDERS
Editor CME
Medical House
Central Square
Pinelands 7405
South Africa

Classifieds and Announcements

The *Gazette* is pleased to publish classified advertisements. These are charged at the rate of 10 pence per word—money with order please. It is helpful if you can include a contact telephone number in case of any queries.

Announcements of births, deaths and changes of address will be published free of charge.

Please ensure that these items reach the *Gazette* office four weeks prior to publication.

Hospital Line

Queen Mary's Hospital in Sidcup has recently introduced a new initiative to ensure maximum utilization of its operating facilities. Operation slots that are made available by patients not turning up at very short notice are now being announced on the local radio station RTM. Patients who are currently on the waiting list at Queen Mary's can phone in and see whether their operation can be carried out instead. In effect patients are being offered a standby service for their own convenience.

John Fahy, who is overseeing the scheme, has said that the hospital is faced with up to 200 last-minute no-shows, and this is one of the ways in which they are trying to provide an improved and more efficient service for their patients.

The scheme which started on 8 February has been introduced with full backing from medical staff, and Mr Fahy claims that early indications bode well for its success.

Tomlinson—costing change

The University of London has commissioned independent management consultants to assess the costs of reconstructing medical education and research in London, a recommendation of the Tomlinson report. The recommendations included merging undergraduate schools with four multi-faculty colleges and reducing the medical student intake in London by 150 places.

A study by KPMG Management Consulting shows that the capital costs of implementing Tomlinson's proposals could be as much as £200 million, to be borne by London University. No attempt was made to assess the costs of Tomlinson to the Health Service. It is unlikely that these changes would be self-financing—an aim of the Tomlinson report.

KPMG concluded: 'There is no doubt that implementing Tomlinson's proposals will not be offset by revenue from disposals and existing funding council grants. Even at the lower end of the projected costs there is a substantial shortfall'.

The UMDS Management Board has released a paper in response to the Tomlinson report. The paper supports the proposed merger between St Thomas's and Guy's Hospitals to form a single NHS trust. The site freed by the rationalisation of clinical services should be developed for academic purposes, including teaching and research. Faculties from King's College should be transferred to this site to combine with UMDS Basic Medical Sciences.

However, UMDS rejects Tomlinson's proposal that the number of medical undergraduate students should be cut, and maintains that the proposed merger with King's College will successfully train 300 medical students a year.

National Epilepsy Week

National Epilepsy Week runs from 16-22 May 1993. It aims to emphasize that a significant proportion of the 300,000 people in the UK who suffer from epilepsy have poor seizure control andmany have poor quality of life. The British Epilepsy

Association (BEA) is attempting to rectify this situation by providing information about treatment and living with epilepsy.

In order to raise funds the BEA is launching a national sponsored walk: 'The Walk To Beat Epilepsy,' which will take place on Sunday 16 May 1993. Details may be obtained from the British Epilepsy Association, 40 Hanover Square, Leeds, LS3 1BE, or the Walk Hotline on (0532) 439393.

Male breast cancer

There are about 170 new cases of male breast cancer a year in the UK. Unfortunately, because the number of men getting this cancer is so small, there have not been any clinical trials to establish the most effective treatment. Such trials would require the cooperation of all surgeons who treat male breast cancer in order to get a significant number of patients (at least half of those diagnosed over a three-year period).

Mr Ian Fentiman, deputy director of the ICRF Breast Cancer Unit at Guy's has said: 'It would be relatively easy to set up a trial and this approach would be an important step towards the rationalisation of treatment for men with breast cancer. However, the most important requirement would be the acceptance by surgeons of the concept of national trials for rare tumours.'

New asbestos regulations

Two new sets of regulations have been laid before Parliament by the Employment Minister, Patrick McLoughlin, to prohibit the use of asbestos and control its use in the work place. The regulations, which came into force in January 1993, include: putting a greater emphasis on the use of alternative non-dangerous substances and limiting the number of workers in an area following an unforseen escape of asbestos into the workplace.

The amendment to the control of asbestos also introduces more stringent control on the level of chrysolite (white asbestos) in the work place. The use of crocidolite (blue asbestos) and amosite (brown asbestos) in Great Britain has been prohibited since 1986.

"Quote-Unquote"

A psychiatry senior registrar during a crisis team meeting: 'I am not sure how old she is...but on the phone she sounded about 50!'

Medical Students' Clinical Survival Guide

The tricks of the trade revealed

It is easy for medical students to become engrossed in (and overawed by) clinical methods books such as those by MacLeod and Hutchinson, whilst having a poor understanding of what is required in practice 'on the ward'. The unfortunate result may be an intricate knowledge of obscurities, but lack of an overall scheme when asked to examine patients (as in Finals short cases), even late in the clinical course. This was certainly my experience as a student. Clearly, it is desirable to help students ascend beyond this stage as soon as possible, and it was with this aim that the present article was written.

How, then, may clinical skills be 'honed to perfection'? Undoubtedly, the best method is regular practice, preferably overseen (and criticised) by a senior colleague, but it is also important to have a mental 'checklist' for examining each body system, which can be rehearsed again and again until it is second nature. In this way, it should become possible to examine patients in a consistent, logical fashion without forgetting important details, even in the stressful environment of an examination.

I therefore thought it might be useful for students preparing for Finals in June (and anyone else for that matter!) to have published the lists that I used for this purpose. Though far from exhaustive, they will I hope serve as a brief, realistic aide-mémoire to short case examination, and provide that most important of things; a structure. It is recommended that these lists are supplemented with short 'clinical methods' books such as *Short Cases for the MRCP* by Charles Hind (Churchill Livingstone, 1992), and *A Medical Catechism* by John Rees (Hodder and Stoughton, 1986).

Cardiovascular Examination

Inspection

- General: (from the end of the bed) distress, tachypnoea, pallor, cyanosis (lips), malar flush [mitral stenosis]

- Hands: clubbing (if borderline say: 'I would consult a senior colleague for his opinion, and certainly exclude possible causes'), cyanosis (nail bed), warm/sweaty
- Face: anaemia (both lower lids at once. If unsure say: 'I would be suspicious of anaemia'), cyanosis (underside of tongue)
- Mouth: (briefly) state of teeth (caries may cause infectious endocarditis), tongue (glossitis), angular stomatitis
- Tibial oedema (or pre-tibial myxoedema)
- Radial pulse (rate, rhythm)
- Blood pressure (if no cuff say: 'I would like to know the patient's blood pressure'—they will probably tell you)
- Jugular venous pulse (remember to look for waves)
- Carotid pulse (eg 'strong pulse with normal waveform')

Palpation

- Apex beat [tapping in mitral stenosis], heaves (apex and parasternal), thrills

(Percussion)

Auscultation

- Listen to all four heart areas using both bell and diaphragm in each. (Make sure stethoscope is pressed into skin hard enough), and then around remainder of chest (explore carefully and take your time), finally returning to the mitral and aortic areas.
- Mitral: Listen, lie patient on left side, breath held in expiration, then listen again [radiation to axilla implies mitral regurgitation]. Is murmur louder? In general, left-sided heart murmurs are louder in expiration, and right-sided murmurs louder in inspiration
- Aortic: Sit forward, breath held in expiration [radiation to neck implies aortic stenosis]. Listen for carotid bruits. Listen for basal crepitations (especially late inspiratory crackles due to pulmonary oedema) at back of chest. At the same time test for sacral oedema, though 'officially' one needs to press for one minute!

Miscellaneous

- If stopped by examiners say: 'I would also like to...'
- Check for hepatic enlargement [pulsating and tender in tricuspid regurgitation], presence of all pulses, radiofemoral delay, oedema (and how far up it extends). Inspect and feel calves [deep venous thrombosis]. Auscul-

tate for femoral bruits and abdominal bruits [abdominal bruits in renal artery stenosis]

Respiratory Examination

Inspection

- General: 'Inanimate' items eg sputum pot, oxygen, nebuliser, salbutamol, peak flow meter, chest drain [pleural effusion]
- Respiratory distress (accessory muscles used?), respiratory rate (increased?), pallor, cyanosis, chest shape (barrel chest?). Ask patient to hold arms outstretched arms straight and horizontal, wrists extended. [Flapping tremor implies CO_2retention]
- Hands and face: (as above)
- Lymphadenopathy (especially supraclavicular)

Palpation

- Trachea: put index fingers between sternomastoids to see if they go in the same amount (will do so if trachea central. A relatively comfortable method)
- Expansion: upper chest (keep fingers together, hands vertical). Lower chest (hands around chest as much as possible. Don't let hands move on their own)

Percussion

- Compare sides at each level (wrist action for percussion—needs practice). Percuss above clavicle, clavicle, then three levels to base (do not forget lateral aspect). When percussing the back it is easier if you can get behind patient rather than side on. Tactile vocal fremitus (use the palm of hand)

Auscultation

- Use diaphragm of stethoscope (listen for breath and added sounds)
- Whispering pectoriloquy

Miscellaneous

- Measure peak expiratory flow rate

Abdominal Examination

Inspection

- Hands: [Dupuytren's contracture]
- Eyes: [jaundice]
- Mouth: teeth, tongue, ulceration, pigmentation

- Thorax: Lymphadenopathy, check front and back of chest for spider naevi and gynaecomastia
- Abdomen: spider naevi, movement with respiration, symmetry, scars, testicular atrophy

Palpation

- Palm should be flat to the abdomen. May be useful to kneel to do this. Gentle palpation in clockwise direction in the four quadrants, then deeper palpation
- Specifically feel for liver, spleen and kidneys. To feel spleen roll patient onto right side. For kidneys, hand must be quite medially place and deep palpation required. Feel during inspiration
- Exclude aortic aneurysm (hands either side of umbilicus)

Percussion

- Liver: vertical height in mid-clavicular line normally
cm (rest middle finger in rib space. Start from high up.
- Spleen: go above costal margin (finger in rib spaces as horizontal as possible, to feel level better)
- Flank dullness implies peritoneal fluid (ascites). Demonstrate shifting dullness and fluid thrill

Auscultation

- Listen for at least one minute in all four quadrants.
- Check for bruits [renal artery stenosis]

Miscellaneous

- Check hernial orifices (ask patient to cough).
- Palpate femoral pulse and exclude femoral aneurysm (can cause pain or acute abdomen, or may be confused with a hernia).
- Auscultate for bruit. Examine for scrotal swellings (note size and consistency). Finally, say: 'I would like to perform a rectal examination'. If appropriate also express desire to test for faecal occult blood

Neurological Examination (eg of the legs)

Motor

- Observation: posture, wasting, tremor, choreiform movements, fasciculation
- Tone: Reduced in lower motor neurone disease. Increased in extrapyramidal lesions (with lead pipe or cogwheel rigidity) and upper

motor neurone disease (with spasticity; test by brisk knee flexion which feels like a clasp knife). Test each leg separately

- Power: On a scale of 0-5. Work down from 'top' (eg iliopsoas—hip flexion). Best method of ensuring accurate cooperation is to demonstrate a position and ask the patient to resist your efforts to move the limbs out of that position; try to keep to chosen method throughout.
- Reflexes: learn best limb positions for testing. Symmetry is essential. Use reinforcement if necessary. Test for ankle clonus
- Coordination: heel shin test

Sensory

- Demonstrate the sensations to be elicited at top of sternum, with the patient's eyes open. Subsequently ask him to close eyes and say 'yes' when something felt. If testing pain ask whether a painful sensation or just pressure is felt. Ask if the sensation changes at any time.
- Touch, pinprick, vibration (128 Hz), joint position sense. Romberg's test

Gait

- Remember to ask patient to walk about

John S Gilbody

'Eurotalk'—an EMSA Weekend

Franglais for medics

The European Medical Students' Association (EMSA) is a young organisation run by students for students, and one which has quickly emerged as a society capable of running activities as diverse as rural village programmes in Turkey, ski trips in the Czech republic and language weekends ('Eurotalks' as they have come to be known) in Sheffield. Thus, it was at the start of one cold January weekend that four UMDS students set off for a Eurotalk at Burton Manor College.

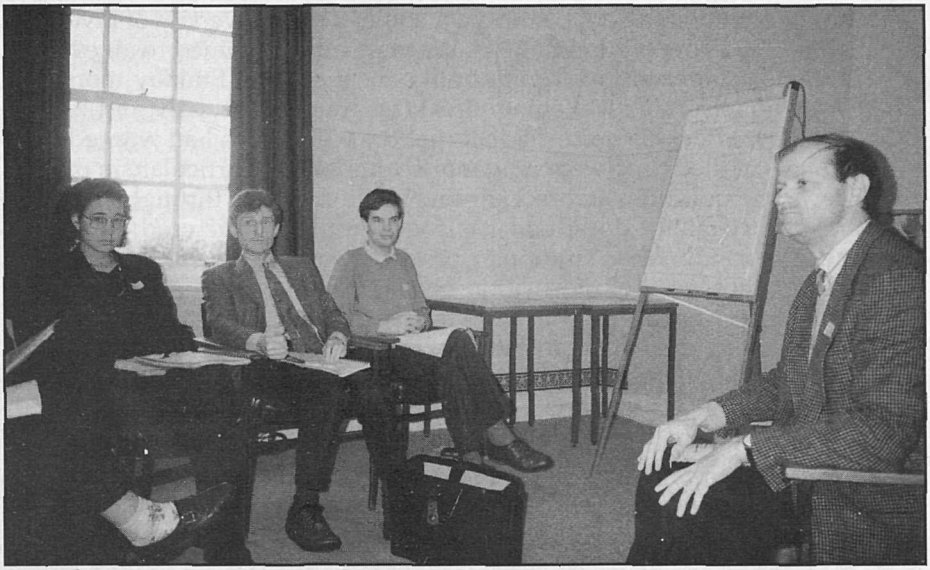
We arrived late Friday night at the college, located in a secluded spot in the Wirral. The college, set in well landscaped gardens, was to be our home for the weekend. A French weekend involving drama, good food, jazz and oh those chic French women.

The University of Liverpool language and medical departments together with EMSA organised a series of workshops which centred on how to take a history and examine of the various body systems. The workshops consisted of medical students, GPs and hospital doctors with a French exchange student from the ERASMUS scheme chairing the proceedings. Teaching was in the form of role playing *le médecin et le malade.*

A welcome addition to the teaching staff were two guest doctors, Dr Julian Donckier and Dr Arnaud Roth from Hôpital de Mont Godine, Belgique and Hôpital Cantonal Universitaire de Genève, Suisse respectively. They taught us the finer points of French medical terminology; quite an achievement if the pupils do not already know the finer points in English!

However, these two sessions proved invaluable as one also got an insight into both how medicine is taught on the continent and how their health care systems operate in comparison to the NHS. It was, how you say in English, an eye opener.

A little forethought and careful planning can minimise potential problems. *Une bonne idée* was to take into account the varying standards of French proficiency and put participants into one of 10 groups. Group 10 had the most



Dr Julian Donckier discussing the career pathways of the different specialists in Belgium.

fluent speakers, while group one contained the novices. The mix of medical students, GPs and hospital doctors worked well.

Besides intensive learning there was also time to socialise. Coffee breaks were frequent allowing mingling and informal chats to go on. Some of the most amusing conversations took place over lunch and dinner. Topics included the French pastime of dipping biscuits into tea and coffee, and the encouraging notion that French spoken with an English accent was considered charming. Also present amongst the GP contingent was a Dr Mark Cottrill who, besides being a Guy's graduate, was one of the founder members of the Anglo-French Medical Society. The society which has existed for the past 10 years organises weekend French language courses which are aimed at improving fluency in French by a variety of methods including the use of video film, slide presentations and articles from recent magazines. At present French members outnumber their English counterparts. Membership is also open to undergraduates at a reduced subscription rate of £5.

Saturday night was an opportunity for some of the University of Liverpool medical staff to show off their talents. We were all entertained to an evening of jazz. Sunday morning was quite unlike most student Sunday mornings. There was no leisurely awakening. Breakfast was served early and lessons quickly followed. It was quite evident that the workshops had worked well. All members of the group were now more confident and articulate in putting their views and questions across. Learning medical French through role-playing and history-taking does lend itself very well to structured systematic learning. The handbook so studiously prepared was referred to frequently as it contained most of the information needed for the course. The weekend proved to be very rewarding and good fun; so much so that I can't wait for the next one. For the excellent organisation of the weekend, due credit and thanks must go to the language and medicine faculties of the University of Liverpool, with a special mention for Dr Gareth Williams and Jane Hoskings, the EMSA representatives at the University of Liverpool, and last but not least, to those chic French ERASMUS students.

Eurotalk participants—exhibiting sunny smiles for a sunny day

Some of the forthcoming EMSA events:

April 12-18
- EMSA Orchestra meeting, Wurzburg

April 24-25
- EISS (Science conference) Amsterdam
- EMSA Spanish Eurotalk, London

May 4-5
- EACE Linkoping, Sweden
- Ethics conference: 'East meets West', UMDS, London

Summer Holidays
- Turkish summer schools and village rural programmes
- 3rd International Medical Students' Camp, Moscow and St Petersburg

Details of the next course can be obtained from Dr Gareth Williams, Department of Medicine, University of Liverpool, PO Box 147, Liverpool L69 3BX., and for further information about the Anglo-French Medical Society write to: Dr Mark Cottrill, The Moat House, Lymm Hall, Lymm, Chesire WA13 OAJ.

Joseph Kamal Muhammad
4th year EMSA representative

Passive Smoking at the Science Museum

We take a look at what the exhibition has to say

It is estimated that every year approximately 300 people in the UK die from lung cancer, caused by passive smoking. However, scientific evidence is still equivocal and passive smoking is still very much a controversial topic. Should smokers be forced to stop smoking in public places? Concerns about the consequences of passive smoking amongst the general public have been paralleled by increased exposure that this issue has received in the lay media.

Passive Smoking, the latest in the 'Science Box' series of contemporary science exhibitions, is currently being held at the Science Museum in an attempt to illustrate this topical issue.

Dr Brian Mawhinney, Minister for Health, who opened the exhibition on 14 January said that, 'although the vast majority of tobacco related lung cancer deaths occur in smokers, there is now mounting evidence that around one person a day, who does not smoke, dies from diseases resulting from inhaling tobacco smoke over many years.'

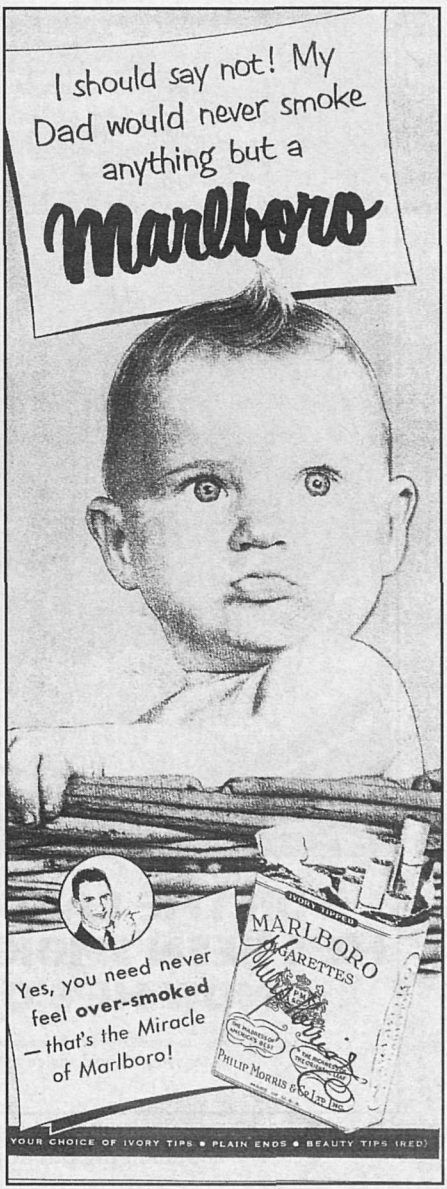
By way of a New Year's resolution, the Science Museum introduced a no-smoking policy on 1 January 1993. With the evangelical zeal of the newly ex-smoker, its Passive Smoking exhibition seems to evoke guilt in any smoker amongst its audience. A specially programmed totalizer, giving a running display of the average number of deaths from smoking related diseases since the New Year, dominates the exhibition. Children can play on a macabre, life-size human jigsaw, illustrating the effects of passive smoking on different parts of the body. Further information is provided by computer interactive displays (interactives) which summarize the literature that links passive smoking to bronchitis, lung cancer, childhood 'glue-ear' and the aggravation of asthma.

Another display identifies over 4,000 chemical constituents in tobacco smoke, of which 43 are carcinogens. Scientists have shown that passive smokers do absorb chemicals from tobacco smoke. By measuring urine cotinine (a metabolite of nicotine) levels in passive smokers, it is estimated that people

who work in smoke-filled offices 'passively smoke' the equivalent of three to four cigarettes a week. Information is pitched at a basic level, to give the non-medically trained visitor an understanding of the pathology of smoking-related diseases, whilst further information is available from a leaflet. In addition all displays and interactives end with a reference list to substantiate statistics and give supporting evidence.

At a more personal level, visitors can also investigate the impact that the smokers in their lives are having on their health, with a 'Smokerlyzer'. This device measures the carbon monoxide content of the breath. [Carbon monoxide from tobacco smoke remains in the body for 4-6 hours, so passive smoking can be measured during this period.]

Not only does the exhibition give information, it is also gathering it. Over the last decade, there has been a move away from the idea of smoking as a right, to a belief that people have a right to a smoke-free environment [British Social Attitudes—the 8th report, 1991]. Using a computer interactive, visitors are able to take part in a six question opinion poll expressing their own views about smoking in public places. Results so far are in accordance with the Social Attitudes report—that the majority now support the introduction of restrictions both on smoking in public places, such as cinemas and shops and on public transport.


I should say not! My Dad would never smoke anything but a
Marlboro
Yes, you need never feel over-smoked — that's the Miracle of Marlboro!
MARLBORO
CIGARETTES
PHILIP MORRIS & Co. LTD.
YOUR CHOICE OF IVORY TIPS • PLAIN ENDS • BEAUTY TIPS (RED)

FOR THE LAST NINE MONTHS
HE'S BEEN SMOKING CIGARETTES,
NOW HE'S ON TO A PIPE.
Giving up smoking is not easy, especially when you're pregnant.
If you'd like some sympathetic advice call the Quitline on 071 487 3000 or contact:

The changing public perception of smoking.

Wednesday 10 March is National No-Smoking Day. To mark the occasion, the Museum will hold a 'table-top science' day, where people can take part in experiments to investigate the effect of cigarette smoke on themselves. 'Dragon's Breath', a dramatic performance for 7-11 year olds on the theme of smoking and passive smoking will also be held. In addition, a talk on passive smoking will be given by Dr Graham Cope of the Queen Elizabeth Medical Centre, Birmingham. The talk will be aimed primarily at adults and children over 13 years old.

Passive Smoking is the fourth in the Science Box series of contemporary science exhibitions. The Museum has moved away from its dry image as a custodian of objects of scientific value, in favour of interactive displays and discovery learning—the visitor is educated by play. Forthcoming topics include the Olympic gold medal winning LotusSport bicycle and nanotechnology (technology on an atomic scale).

The Passive Smoking exhibition is a low key, low cost affair which succeeds in entertaining, whilst addressing a serious health issue. It is visually interesting and well worth a visit, being particularly poignant if you are a smoking parent.

A Russell

Home Again

Dr Pitt-Payne returns to Guy's

It is always very refreshing to hear of a good domestic fight where the wife has fought back—manfully. The husband—a gentleman to his fingertips—had been driven to such distraction by his good lady that the red mist had begun to swirl about, but not before his wife had tried to throttle him with his own tie. His attempts to restrain her had only made matters worse and such was the row in their flat that the police had been summoned by neighbours. As they lived in police accommodation it goes without saying that their neighbours were all policemen—to a man; for those were the days before the arrival of the WPC or indeed the woman priest. Somewhat unwisely, he had turned his back for just a split second and received the coal scuttle in the nape of the neck, which threw him against the wall where his nose was duly flattened and he was covered in black dust. At this juncture, the bell rang and he staggered to the door and opened it. On seeing his colleagues—and they saw him all covered in coal dust with his tie knotted under his left ear, his collar askew, and blood about his face and mouth—he said:

'Never mind, lads! I'll get her the next time round!'

The East Wing

So it was on my return to Guy's in November 1970. I can't claim to have been knocked about to the same extent but a lot had happened in a very short time and the more I saw, it seemed the less I knew—and this process has continued to the present day. My predecessor was John de Carteret, a Cambridge man with a quiet smile and a V12 super-charged brain. A hard act to follow. I have mentioned Dr Mann, Dr Scott, and Professor Tim Clark before but it was their registrars who took care of business on the day-to-day front. The Senior Registrar was Dr Ian Roberts (C I Roberts) and the Junior Registrar was Dr Colin Brown (C B Brown). My name tag said I was Mr J H Pitt-Payne which used to confuse the patients because it was a custom then to refer to all pre-registration doctors by the title 'Mr'. One became 'Dr' from the SHO grade upward until such time as one achieved the Final Fellowship in Surgery when one reverted to 'Mr'. Ian Roberts was a thoroughly decent fellow, with a languid style and an informal way of approaching clinical problems. I remember Dr Man asking him—and the firm—how they should go about treating

attacks of gout. Ian plumped for allopurinol whereas Willy Mann favoured colchicine; supplies of which he invariably kept in his car. Colchicine could abort an attack of gout and I was surprised to see that, whilst no longer listed in MIMS, colchicine is still available—as is quinine sulphate, of course, another sovereign remedy—but for something else.

Colin Brown was adjacent to me in the East Wing during our weeks on take-in. I had started in Room 42 on the third floor when I was a House Surgeon but then came down a floor to Room 21 for the HP job. Colin proved to be a light sleeper when we were on 'take', with a tendency to bang on the wall if the volume of things happening in my room became too much for him. I thought this very reasonable but I would have been grateful if the silent bed-spring could have been invented sooner. Certainly the set-up with those strange beds we had to pull away from the wall took some getting used to and there was very little room in them when they were barely two foot six wide. The radio was untunable and I never mastered the controls. I strung string across the room so I could hang my socks up to dry. It was always a wise move to wear a fresh pair of socks twice in 24 hours; just as it was essential to remember to eat. However, there were other things on my mind such as my glamorous new fiancé who came to call, when Room 21 became our 'head-quarters'. Night-time in the East Wing was just as extraordinary as night time in the West Wing and the comings and goings, too-ings and fro-ings were nothing short of enlightening. It became possible to see who was doing what, when, and with whom. We tended to meet people coming out of lifts at the most amazing times of day and night and many's the night I escorted Jaqui back to the West Wing at 4am—or thereabouts. Odd how I had the stamina for it all on those days but it was a wonderful time and the supplies of energy seemed endless.

Duty free duties

Quite a few of our chest cases flew in from the Channel Islands for treatment. One such chap was Henry. He had come over for DXT some five times a week and on Friday afternoons he would go back to Heathrow, through customs and out to the Channel Islands. It occurred to me, with almost indecent haste, that I had struck on a means of getting absolutely first class duty-free booze, and happily for me Henry was not a drinker. Each time he came back on the Sunday evening there would be a couple of bottles of VSOP Port for me to keep in my room—and after I had tried to reimburse him for the stuff, he always refused—which was even better! After a couple of weeks Colin and Ian had cottoned on my scheme and wanted to join in too. It was hard to say

'no' to them and it gave further substance to that old adage that one man's meat is another man's poison.

At that time we were treating polycythaemia rubra vera in a new way; doing a three pint venesection with some high molecular stuff going in to the other arm with the same speed as the red stuff came out of the ante-cubital fossa and into the jug on the floor. I found that I had a penchant for teaching whilst on this firm and I enjoyed the stage management of such events. The results were always dramatic, in that florid-faced gentlemen, who had puffed and wheezed at every step, soon stepped out in style down the ward and went home rejoicing. The alternative, of course, was the radioactive phosphorus treatment which was something of an anti-climax in comparison. Who can forget the inimitable Dr A B Wayte as he handed a glass of what appeared to be water with a straw in it to the polycythaemic patient?

Take-in weeks produced their invariable crops of stroke and these lay inertly in the first five or six beds of any ward round. We seemed to have a crop of them on Mary Ward, Hunts House. I must admit that they made me feel a bit helpless as they took up bed space. One day I was walking down the ward towards the door when I felt something hit my white coat and fall to the floor with a familiar thud. I stopped, looked down, and saw that the patient in bed 5 had thrown a piece of excrement at me with her right hand. She had had a dense left hemiplegia. I never forgot that. Although my ability to communicate with these unfortunate victims was limited by my age and inexperience, this one had no qualms about chucking a mud-pie at me, and the message implicit in such an action spoke volumes as to how she must have felt about me. She had never thrown anything at anyone else before. Sadly, it was the last thing she ever did, so I never did get to the bottom of it.

The 23 causes of vertigo

There was a registrars' round every Monday morning and here we went into the management of each case at exhaustive length prior to Dr Scott's round on Monday afternoons. Ian Roberts and Colin Brown took their work very seriously and chewed hard over each case. I had learnt quite a bit about Dr Scott's technique on teaching rounds whilst serving as student at St Nicholas's Hospital, Plumstead. One such case involved a man with vertigo and it was inevitable that George Scott would wind up the proceedings on such a case by saying:

'Well boys! It all boils down to the causes of vertigo.'

We would then be expected to come out with them, one at a time, starting from the ear outside and working inwards towards the brain. On that particular occasion, Gerald Peters (now a GP at Leigh-on-Sea) and I discovered 23

different causes of vertigo; listed them; memorised them, and then waited for the question we knew must come at the end of a discussion on such a case. Everyone knows just how satisfying it is to be able to come up with the right answers at the right time—and it happened for us at St Nick's, Plumstead, in 1969. For the life of me, I could never remember the 23 causes of vertigo now! I remember Gerald Peters from the anatomy days prior to 2nd MB. He was a mature student who had come to medicine late having practised as an ophthalmic optician, and he had the rare distinction of having won the Gold Medal in the old FBOA examination many moons before. He was the perfect partner for studying with and he had an eye for the detail and the understanding of the fundus which left us all standing. I have this memory of him sitting alone in the dissecting room pouring over the contents of the mediastinum as though he might have been handling the crown jewels. It was he—more than anyone else—who helped me to understand what I saw with the ophthalmoscope.

Banana sandwiches for tea

These registrars' rounds were, as I have already stated, rather serious affairs and as the weeks began to whiz by and I got into my stride I felt that all work and no play may have made Jack—or in my case, James—a dull boy. The Ward Sister, Sister Jane Cox, had a twinkle in her eye once I got to know her and in the fullness of time she became engaged to Graham Hey who was on the House at the same time as myself and had also gained a second house job. On, or about the second or third case into the ward round, I would find myself interjecting with the odd remark:

'Sister?'

'Yes, Mr Pitt-Payne?'

'Will we be having banana sandwiches for tea on Dr Scott's Round this afternoon?'

'Yes, Mr Pitt-Payne.'

So far, so good. Not a facial muscle moved and the conversation with regard to the patient would continue. Two beds later, my feet would begin to twitch again:

'Sister Cox?'

'Yes, Mr Pitt-Payne?'

'Will you be adding a coating of sugar to each banana sandwich, Sister?'

At this stage her composure would start to crack so I left off with my next question until the next bed when a lull in the conversation with regard to future management occurred:

'Sister Cox?'

'Yes, Mr Pitt-Payne?'

'You won't make them until the very last moment, will you? Only I can't abide soggy banana sandwiches.'

At this point there would usually be a comment from Ian Roberts to the effect that I was lowering the tone of the round. For a Senior Registrar, he was a long-suffering chap and he tolerated all my nonsense terribly well. Personally, I felt it helped to pass the time. In due course, we all lapsed into the vernacular of our Christian names with one another—which was rather nice and a sign that times they were a-changing.

George Scott's Round always started on Miriam Ward, the Mens' Medical, and when we finally entered Mary Ward I would be up front with my best smile:

'Dr Scott, sir—Sister Cox has made banana sandwiches for tea!'

If George Scott was amused, he always kept himself under control although we all has the feeling that just under the surface there was another man just bursting to get out and join the fun. It was this and so many other traits that endeared him to so many of us through the years but he always enjoyed playing the role of the Teaching Hospital Consultant Physician to the hilt. I would have loved to have been present on the apocryphal occasion when Russell Cowan was his HP. The story went that George asked as to why 'this patient' had had a mastectomy and Russell's reply was supposed to have been:

'Because she wanted to improve her golf-swing, sir!' (Russell Cowan MD FRCP is now Consultant Physician at Colchester).

Firm dinners

I haven't said anything about the firm dinners I must have attended whilst at Guy's. All of them were memorable but the best of all were those where I was either HS or HP on the firm in question. After the psychiatric firm dinner, for example, we finished up in the Residents' Bar and Warwick Onyeama and myself stood atop the bar itself and did the Zulu Warrior Dance. I only know this happened because I was told what I'd done the following day. On other occasions I'd appointed myself unofficial pianist for the evening only to find that I couldn't play a note when I finally came to it because my central nervous system no longer wanted to operate. When I was a House Officer, though, it behoved me to stay at the helm and this I somehow managed to do whilst mayhem became the order of the evening all about me.

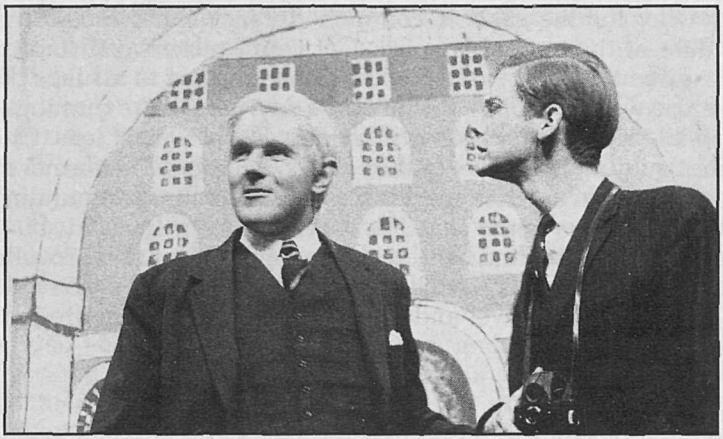
I must have attended a Rose ball or two in the time I was at Guy's and these were notably rowdy occasions. I always felt sorry for the cabaret artistes who had to try and perform against the sternest opposition. One such performance, a delightful woman with a very pleasing voice, can't have found it too easy, when, in the middle of a particularly moving song a certain orthopaedic senior

registrar, who, for the sake of common decency must remain nameless, shouted out—at the top of his voice: 'Get your knickers off!' and thus very nearly unseated the good woman who was attempting to assuage the terpsichorean muse while warbling the hit of the day. Two years running I had the worst possible luck in that both my partners lost a contact lens. One on the floor of the Savoy and the other in the Nurses' Quarters. The former managed to throw up in my car as it traversed Leicester Square thus confounding certain plans I had had for her with White Horse Whisky from one of my bilateral hip flasks. The latter never found her contact lens and by the time I grovelled about the floor searching for this wretched item, the mood of the moment had left me and I threw in the towel and went home at some ungodly hour of the morning.

The Residents' Play

The preparations for the Residents' Play had begun early in December 1970 and early on it was intimated to me that I had been selected to take off Guy Blackburn. As I was tall and still moderately slim, it would take at least six incontinence pads, an old school tie (Rugby I'll be bound), and a well worn suit kindly loaned by Mrs Blackburn. I was also measured for a wig and that, together with the obligatory half-moon spectacles, would complete the ensemble. It was the frenetic behind-the-scenes preparations which made the whole experience so enjoyable. I never really knew the difference between a director and a producer but it was Piers Rheinhold that bore the brunt of the nightly attempts to knock the cast into some kind of shape. Rehearsals began at 10pm each night and went on for two to three hours some five nights a week. Piers was the ENT House Surgeon and he managed brilliantly in the way he went through the gamut of his own emotions in order to extract the necessary performances from such a reluctant troupe of thespians. I had first met him back in 1965 when we had sat next to each other awaiting our first admission to Guy's. He threw himself into the enterprise with a suicidal, gung-ho type of intensity which was what it would take to get the best out of us. Few of us were natural performers and it was the custom to select the most macho members of the House to play the nursing roles viz Graham Hey (Hooker for the Guy's 1st XV and holder of many Kent caps), Tony Quant (elder brother of Mary Quant and eventually Air Commodore in the RAF Dental Branch), and David Bostock (now a GP in Stockport Cheshire).

Michael Simpson, the writer of the play, doubled up as Lord Sea of Beachy Head (aka lord Cohen of Birkenhead) and Sister Fix (aka Sister Rix). As the former he was formidable, but it was as the latter that he/she stopped the show with a striptease that quite outdid the dance of the seven surplus army



Dr Pitt-Payne as Guy Blackburn (left), and Malcolm Hillier as Rex Larne (right). Residents' Play 1971

blankets with a magnificent series of bumps and grinds and that tantalising but nevertheless stomach-churning display of flesh which formed part of the inevitable conclusion which we were spared when the Stage Manager dowsed the lights.

Those chosen to be 'done' always got the best seats where we could all see them and they all—to a person—always took it terribly well. Guy Blackburn came to the Wednesday evening performance and laughed so much that he ricked his neck and had to see Adrian Henry the following day for a spot of advice.

Writing the words for the song was a challenge because they had to be written on the spur of the moment in what would now be thought of as a 'brainstorming' session. There was a meeting of the writer/director, producer, and various interested parties, and then we went off for an hour with the brief that we were to return with the words to a particular song. This was achieved and then Michael Lavelle (an Oxford Graduate who had come to Guy's for his clinical period) set everything to music. This was the clever bit and we have him to thank for some super music. Every intake produced its musicians of course, and the orchestra of the day was composed of Michael Lavelle, John Sargent, Lyn Callow, Peter Inward, Colin Baker, and Hugh Fuller.

J H Pitt-Payne

A Day Out in the Ambulance.

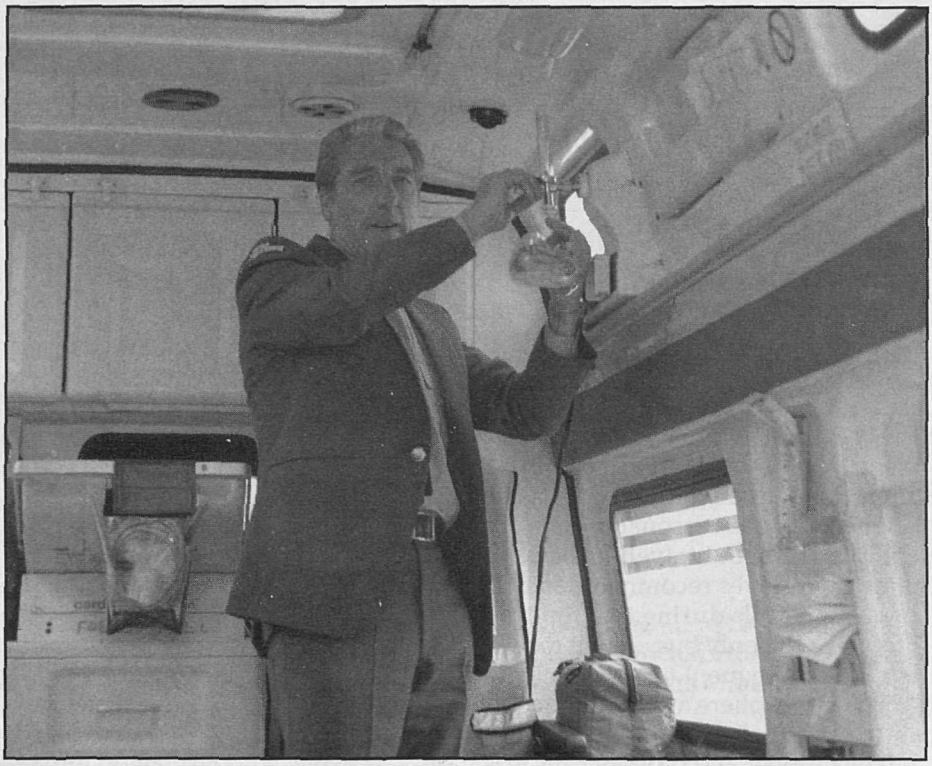
Ambulance duty in the A&E quartile

Our firm was attached to crews based at Rotherhithe, next to what was once existent St Olave's Hospital. Two students attended every Thursday morning. Early shifts start at 6.15am and it's a good idea to make sure you are not on take the night before (the orthopaedic firm is one of the few in which senior members of the orthopaedic team actually bother to bleep you, and casualty is usually fairly busy too). Previously, students were attending the late shift, which was from 3.00pm to 11.00pm, which, to our firm, seemed a more reasonable time. However, students in previous firms had complained about travelling back to their place of abode that late at night. The crew themselves recommended the later shift for students as they tend to be have more calls during that time. It helps if you have a car or live in Landale House as the only bus, which fortunately stops directly opposite the hospital, is not very frequent (especially in the early hours of the morning).

The atmosphere at the Rotherhithe post is very relaxed; all our firm found the crew members to be very friendly.

The number and types of calls was varied, as expected. The general impression was that most of the calls sent out were made to seem more urgent than appeared when one actually arrived at the scene. Ambulance crews also get called to provide a taxi service, so one should expect to go out on calls ferrying people to outpatient appointments and such like. The few 'blue light' calls to acute medical or trauma situations are well worth experiencing. Be prepared to hang on for dear life as the ambulance squeezes into narrow side streets and inbetween cars, speeds down the wrong side of the road and especially beware of roundabouts. What was surprising was that the crews receive no 'route training', and unlike the police, they have no driving refresher courses. It all goes to highlights the necessity for the crews to always be on the alert.

In London, with the proximity of several accident and emergency units, many ambulance calls involve just 'scoop and run' operations. The crew did highlight differences in training and responsibilities in different ambulance services throughout the country. For example, those offering services in more



A guided tour of the vehicle (**Photo:** Saikat Banerjee)

rural areas are trained to be able to administer more drugs, since they may have to travel that much further before being able to deposit their charges in the safety of a hospital.

On arrival at the scene, we learnt how first aid was carried out (properly!). Although we were warned that we were present exclusively as observers, some crew members didn't mind medical students helping them so long as they didn't take over the situation, as has happened in the past. However, for legal reasons, don't expect to be given any major responsibilities.

During the course of the day, the crew will usually give a guided tour of the vehicle and the equipment that is carried. This usually happens quite early on in the day, but really depends on how busy they are. One can also get to

(**Photo:** Saikat Banerjee)

practise the use of some of the equipment such as inflatable splints and neck braces—particularly useful if you don't happen to be the subject.

It is only when one is involved with the ambulance service that one can appreciate some of the problems that ambulance crews face. Delays at the scene have often been due to delays in processing the 999 calls at central control. The failure of the despatching computer system to cope has recently surfaced in the media. Hopefully with the current changes in the system, one will be able to see an improvement of the service. As everything is computerized, some time is consumed clocking in everything that has been done. In theory, this system does have the advantage that, if on arrival of an ambulance to hospital, an incident had occurred nearby, it would supposedly register on the console carried in the cab when the crew went 'green' and were ready to accept the call. This would obviate the need for the crew to return to their station before they could accept another call. In addition, crew members carry bleeps so it is possible to leave the vehicle for a spot of breakfast, lunch, tea etc.

Crew members also appear to get complaints lodged against them by GPs every week. This tends to be mainly due to the lack of communication between the GP, the patient and the crew, rather than being purely the fault of the crew. Staff in the admitting hospitals sometimes voice frustration at crews for bringing patients who don't need hospital services. This does not happen very often and Guy's casualty staff have been described by the crew as possibly the most understanding.

All in all, spending a shift with the ambulance crews is an excellent opportunity for learning about the one of the paramedical services that is part of health care service in this country. It is an opportunity that should not be missed and, it is, of course, great fun!

We would like to convey our thanks to the ambulance crews at Rotherhithe for accepting students—keep up the good work.

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Donald Vaughan

Donald Vaughan, a general practitioner surgeon for 49 years at Cromer, Norfolk, died in November 1992 at the age of 94 years.

During World War I, though under age on enlistment, Donald served as a pilot with the Royal Flying Corps. He was posted to the Midlands and later to the west front in France. Here he came down behind the enemy lines and for a year was a prisoner of war (POW in Germany. After the Armistice he entered Guy's Hospital as a medical student in 1919, qualified with the MRCS and LRCP diplomas in 1923 and spent two years in house-appointments at the hospital.

In 1925 Donald was invited to undertake a six month locum appointment in a general practice at Cromer. He became a partner and remained there for the rest of his life, retiring from the practice in 1974. For most of his years in practice at Cromer this was a large one that also had partners at Sheringham and Mundesley—now it comprises three practices —and the practice was closely associated with Cromer and District Hospital. The hospital underwent major enlargement in which Donald played a major role. Most of the partners in the Cromer practice had specialty interests. Donald's main interest was surgery and his original intention had been to become a full-time surgeon; he also had special interest in obstetrics. Until he had to retire from his hospital appointment under the age limit Donald was mainly responsible for acute surgery of a large area of North Norfolk and for much of its elective surgery. This work he carried out to a high standard at Cromer and District Hospital where he had the reputation of being a safe and careful surgeon. His partner with a specialty interest in medicine was also a Guy's man, R B Fawkes (Guy's 1923), who won the DSO and the MC as a combatant officer in World War I, and held the MRCP diploma. He predeceased Donald Vaughan as did another Guy's partner, W H Miller (Guy' 1927), who had special interest in ENT surgery.

In his early days at Cromer Donald used at recount that some of his visits to the more distinguished patients were made in a brougham driven by a coachman and he had a host of other memories of the changes in medical practice that he had witnessed. He developed a large practice in Cromer and District and was held in widespread local respect and affection. For many years he bore the then more onerous responsibilities of senior partner of a large practice as well as carrying out his duties at his local hospital. He was also medical officer to the Fletcher convalescent home for the Norfolk and Norwich Hospital at Cromer and retained the post when, in 1957, this was converted to a hospital for geriatric medicine and was renamed the Fletcher Hospital. He was also active in the St John's Ambulance Brigade, served as divisional surgeon and became a Commander of the Order of St John.

A special professional interest was that of a lifeboat doctor and he was the first doctor to go out to sea with the Cromer lifeboat. Donald was a keen sailor and for many years owned and sailed a boat on the Norfolk Broads. He enjoyed the special comradeship of the lifeboat services. His services were frequently needed at sea and during World War II he was exposed to dangers of enemy action as well as the elements. His affection for the lifeboat services was reciprocated by those

with whom he served. He was made life-president and the Institution awarded him their Gold Medal. Recognition of his professional qualities was also reflected in his election as president of Norwich Medico-Chirurgical Society in 1957 and of the Norfolk Branch of the British Medical Association shortly before the branch's dissolution in 1974. For services to medicine he was awarded the OBE.

Outside medicine Donald served as local town councillor and was a founder member of Cromer and Sheringham Rotary Club. He twice served the club as president and received the coveted Paul Harris award for services to Rotary. His other local activities included the presidency and chairmanship of the League of Friends of Cromer, Fletcher and Mundesley Hospitals. Another activity was his annual visit to London for a reunion of his fellow POW's from World War I. He made his last such visit when he was 90 years of age. At this reunion, there was only one other surviving member, of much the same age and in a wheelchair, so it was resolved to cancel the reunions that had been held for some 70 years.

Small in stature, slim in build, neat in his movements and dress, Donald Vaughan was possessed of tremendous spirit and vitality. For most of his life he carried an enormous professional load and worked long hours. This was especially so with the extra responsibilities he carried during World War II and when he had the misfortune to experience the bombing of his Cromer home by the Germans. His wife Kathleen was at home at the time and was buried in the rubble but, fortunately, was not seriously injured.

He bore his heavy work-load with an attractive light-heartedness and sense of humour and with great support from Kathleen. At the time of Donald's death he and Kathleen had known each other for 85 years and been married for 67 of them. Kathleen, with their two sons and one daughter, survive him together with grandchildren and great-grandchildren.

PSB, OJC and ABS.

Copy for the *Gazette*

Articles for inclusion in the *Gazette* should be supplied double spaced, and preferably word-processed or typed. If handwritten, names in particular should be written legibly. If contributions are prepared on a word-processor, it would be particularly helpful if a floppy disk containing the article is supplied along with a printed copy. Where possible, text should be saved in ASCII format—or if in any doubt, full details about compatibility of different files can be obtained from the *Gazette* office.

All feature articles should be approximately 1,500 to 2,500 words in length. Late news and sports reports can usually be accepted three weeks before publication. Authors are requested to supply a contact phone number in case of any queries that arise. The *Gazette* would also particularly welcome results of any original research carried out in the course of BSc or other project work.

End of Guy's training

Nurses are to suffer a cut in pay this year. Why have we not heard more about this sad state of affairs? Probably because a lot of nurses have not even realised the truth of this statement.

But if a pay rise of half, or less than half, the rate of inflation is all that is granted, then surely it is a true statement? Moreover, when compared to fares to travel to work and the price of some commodities in the canteen, bot of which have been increased in price at a far greater rate than the rate of inflation, then the picture begins to look really grim. So why no protest?

Well, nurses, in common with a lot of other workers, are frightened of losing their jobs. There are many instances, also, of nurses completing their training only to discover that there are no vacancies waiting for them to occupy. At one time nurses were guaranteed a post in the hospital at which they were trained; this is no longer the case, and it is unlikely to be resumed.

Despite the fact that the government has laid down what is, in all but name, an incomes policy, it is therefore unlikely that there will be any opposition to this by nurses. If the employment situation changes, and there are once again fewer nurses than vacancies for them, maybe voices will be raised against a pay cut.

Another aspect about the lack of posts available for trained nurses is the imminent prospect of fewer students entering this overcrowded field. To cut down on the number of nurses in training, Region has refused to fund further Project 2000 courses until the mist surrounding Tomlinson clears.

Tomlinson in itself will limit the number of hospital beds in London. My old school captain, Prof Mike Besser of Bart's (or G M Besser as he was known in those more status conscious days) has been kicking up a lot of dust about his hospital and its possible demise. Let's hope he has better luck than the fate which befell our old school!

The decision at Region not to fund Project 2000 has a disastrous effect closer at home. The Nightingale & Guy's College of Health will no longer be training student nurses after the current sets complete their courses. The closure of the School of Nursing?

Well, not quite. The Nightingale & Guy's College of Health runs a large number of post-graduate ENB courses which will keep it busy. But it does mean we will no longer be turning out nurses who can claim to have trained at Guy's or St Thomas's. This is quite a shattering blow considering the tradition that exists between these two establishments. No more Guy's badges, Butterworth medals—and what of the Nurses' League?

Since there will be no students in the school, who will be looking after the patients in the wards? Silly question—the health care assistants, of course.

This position was likely to come to pass anyways if the implementation of Project 2000 had taken place. Under this scheme students are to be deemed supernumary in the wards. The bulk of the nursing care will be carried out by health care assistants. I hope that someone remembers to tell the patients: if one of them urgently requires a bedpan, or some other attention, they must be trained to shout 'health care assistant', and not 'nurse'.

NURSING NOTES

If there are too many nurses for the vacancies, then perhaps the question to be asked is whether there are enough posts open for nurses. There seems to be an almost bottomless pit when it comes to the demand for care and attention by nurses. Already we hear there is a decrease in the number of clinical nurses simultaneous with an increase in the number of managers. I knew the replacement of Florence Nightingale with her lamp at a bedside by cricketers at Dingey Dell, on the back of tenners, was a sign!

If and when the current economic recession lifts, then we may be faced with an inadequate number of trained nurses, and the resources to train them will be have diminished. Then will come the time for nurses to be able to call for more pay. And perhaps the closure of training establishments will be recognised as premature.

Denis Cobell

PHYSIOTHERAPY NOTES

All the best

I have been writing/ have been responsible for the physiotherapy notes in this august journal since Ronald Cooper dubbed me physiotherapy correspondent on his retirement in august 1988. The time has come now for me to retire. It seems an appropriate time as 1 April 1993 would appear to be a watershed. The new NHS is settling down and people are getting the hang of purchaser/provider divide, although many contracts are still 'block-contracts' the concept for having a purchaser for all work done has permeated the service, no matter whether the purchaser be another directorate, a department, a health authority, a GP fundholder or the FHSA.

There are many new and exciting projects on the drawing board and I will be very sorry not to help them come to fruition but, as this time of a definite change in the life of Guy's corresponds with a certain birthday, it seems timely to lay down my tools at the end of this financial year.

I came to Guy's in March 1969 at the invitation of Jean Watkins, the Principal of the School of Physiotherapy and Group Superintendent. I have 25 very happy years to thank her for. I have met and worked with some wonderful people. It would be folly to try to mention them all here. It all started when I was appointed senior physiotherapist in the medical wards, working in Hunts House on Wilks and Bright with Drs Kauntz and

Baker and Patience Ward in the New Guy's House when it was the women's ENT and DXT ward. Twice a day I would leave the students in Hunts House and repair to Patience Ward. There were also regular forays into the York Clinic and the Nurses Sick Room. After a while I managed to persuade Miss Jenkins the Superintendent to exchange Patience Ward for William Gull Ward, mainly for the saving of the shoe leather—but sensibly to build up medical expertise. What fun we had in the Hunts House attic with Professor Butterfield and his wickerbasket covered with a red and white checked cloth.

It was not until 1971 that Miss Jenkins moved me to the Cardiothoracic unit where I worked happily until the early '80s when the added management tasks, due to the 1982 reorganisation, forced me to hand over the in-patient work and transfer my clinical input to a smaller out-patient caseload.

It would be tedious or would take as long as Pitt-Payne's memoirs to reminisce fully through the myriad of changes within Guy's in structural, personal, professional and academic levels. Not to mention its hundreds of patient patients who have brought such joy and anguish into our lives, some who have dimmed into history and others who are still in the forefront of our minds because of that something special that they gave of themselves.

And so the time has come to hand over that which I have had the honour to hold in trust since 1972. Many things will continue to change. The NHS is changing as are the people within it. I wish the physiotherapy service, its new leader and all the staff a happy and constructive future.

I thank everyone I have had the honour to meet, know and share through good times and difficult times, in work and in play, and I hope that Mr Guy's Hospital will continue to fulfil his dreams of caring for the sick because they are in need—no matter who they are or where they come from.

Diana Innocenti

Communication—that's what we need

I have now survived about six months of student presidency, a fact that seems amazing, especially when I consider that Fuad first asked me to write this in September.

As the President of the Student Union (Guy's Campus), I have been elected by you, the students, to run the place for your benefit and for the benefit of future UMDS students. My purpose in writing this letter is 'communication'. Feedback from you makes my job easier and this 'communication' is something that I feel has tended not to happen as well as it

might. For instance, there may be those amongst you who feel that if this is the first time I have put pen to paper, then what on earth am I doing in this job? I share those feelings to some extent, and so please accept my apology. This lack of communication makes it very difficult for changes to occur. Your particular table in the Spit, your firm or row in the lecture theatre may decide that such-and-such is awful and needs to be changed. If something is ever going to be done about it then the committee should be the next ones to know. We can either do something ourselves or point out the person in the medical school who will be able to help. One plea though, I can guarantee to forget anything that we talk about within two days, so please write it down for me.

I am trying to get some more noticeboards put up in Boland House, with some headings for specific areas. At the moment the only way to get through to people is by a sort of mass saturation effect. If they do ever go up, please keep them tidy, and please *read* them.

Anyway to get the ball rolling, I will now talk about things that have happened recently, some questions I need answers to, and other subjects on which I need input from you. If I mention something you feel strongly about, get in touch with myself, or the committee, via either the pigeon-holes in Boland House, in person or through the offices of the Student Union on the first floor in Boland House.

Balls

The Halloween Ball, which took place on 31 October at the Hop Exchange, was a qualified success. In the end all the tickets were sold, but only after we had dropped the price from that needed to cover costs. The last two Summer Balls, dogged by bad weather, have also struggled. In the light of all this it has been quite difficult to decide if we would be justified in having a Summer Ball this year. We *are* going ahead, but we urge you firstly to go, as it is a very special event, and secondly to buy your ticket as early as possible in order to help the organisers. It is very likely that tickets will not be sold at Cobham on the night.

Dormant Societies

The Student Union supports a wide range of sporting and non-sporting societies. However, we can only justify this if adequate interest in these pursuits is shown. At the moment, for example, there is an urgent need for someone who might be prepared to run the T-shirt screen-printing press, or Quodlibet Society—a forum for inviting guest speakers. The sailing club is run by fifth years, who need an input from other years. Lastly, there used to be a 'curry club' some years ago—does anyone remember that, or want to start a new one?

Boland House

The first floor is provided for the benefit of students. Unfortunately it does seem to be rather under used at the moment, especially with the recent locking up of the old ballroom by the London Fire Brigade. We do need therefore to look at how we can provide better facilities. After some discussions the need appears to exist for the following: a music storage and practice room, other lockers for the clubs, a meeting room, student lockers, a prayer room and space for coffee and relaxation. Obviously, we would welcome comments from students about these and other needs, and how best to achieve them.

Hops on Friday night are popular and well-attended. However, there have been problems with security and we would like to remind you of the following points: do not sign anyone in whose behaviour you would not like to vouch for. *You* will be banned from the bar if there are problems. Banning is also a punishment which can, and will, be handed out to UMDS students at the discretion of the Bar committee, on the recommendation of the Bar stewards. Groups, up to eight in number, may be signed in by a member if all the relevant names have been handed to Terry Mitchell of Medical School Security before 4.00pm.

UMDS Presidency

Richard Probert, whom many of you will know as an enthusiastic member of the Rugby Football Club, is President of the St Thomas's campus committee, and has taken over from me as the UMDS President since February. Despite being campus based, we feel that the interests of future united students are best served by close co-operation. We are discussing whether this would not be best achieved by amalgamating the two campus committees into one UMDS committee. Whilst on the subject of Union officers it is worth mentioning that elections take place in May/June. Anyone who might be interested in taking over from us should start thinking about it soon. We would be very willing to talk to you about it.

Congratulations to the Boat Clubs for joining. It is something that other medical schools have been dreading, and it is my sincere wish that we can start proving them right!

Lastly, just to repeat an earlier plea. If anything I have said strikes a chord, or if you feel we need to do something for you, please come and tell me about it.

William Francis
Guy's Campus President

Rugby Club league news

Guy's Hospital Rugby Club are easily the highest ranked of the hospital rugby clubs in terms of the Courage Leagues. Guy's play in the Courage League London South-West Division III which is a couple of leagues higher than noted rivals such as St Mary's or the London Hospital. The Club now occupies a reasonably satisfactory mid-table position, having lost their opening three games and won the subsequent three games. Remaining league games are on March 13, Millbrook, at home, March 27, Old Wimbledonians, away, and April 3, Warlingham, home,

and support would be greatly welcomed. This is a highly competitive league and the hospital has done extremely well to maintain its position in it, though one suspects, if promotion were achieved, the club would fare equally well in London South.

The overall results at the halfway stage of the season are:

Played 12
Won 8
Lost 4 (sadly all league matches)
Points for 352
Points against 147

Notable wins have included those over the London Hospital 56-0, Shirley Wanderers 62-3 and a mixed Blackheath 2nd/3rd team 48-22.

S J Challacombe

Rugby: 1st XV

Guy's 1st XV v Winchester. Courage League match. Won 23-15.

The Club entered the match having won three of their seven league games and badly needing a win to consolidate their position in the Table. Three of the four losses had occurred early in the season and apart from the loss in Jersey, where the team arrived very late due to flight delays, the team have had an extremely good run, winning seven games.

Guy's began as if the mid week training session by Dick Best, the England coach, had left them exhausted. Winchester kicked off with a strong wind blowing from the Club House end of the pitch and, virtually without a Guy's player touching the ball, had found touch one yard in from the Guy's line. In the ensuing line out the Winchester 2nd row dived over for the score. During this period Guy's made occasional forays into the Winchester half and during these were awarded two penalties, one of which was kicked by Wayne Llewellyn to leave the score 3-5. However, another long kick bounced into touch near the Guy's line. From the ensuing line-out scrum-half Raj's kick was charged down and the flanker just beat Docker to the touch down.

At 3-12 down Guy's at last began to awake and play with some cohesion. This was in spite of the fact that centre, Jeremy Worth, had been injured in his first tackle of the match, concussed in his second and had left the field to be replaced by Ben Challacombe who played at No 8, with Wayne Llewellyn moving to the centre. Thus Guy's back line had a slightly unusual look with Richard Docker playing at fly half instead of his usual scrum half and with neither of the usual centres present. A period of Guy's pressure from left to right was eventually stopped by the Winchester backs, but they had been caught off-side and Wayne Llewellyn kicked a second penalty from in front of the posts. Guy's ran the ball back from the kick-off and a good break by Nigel Baker (the coach) playing instead of Alan Jones in the centre, led to a try mid-way out after he had side stepped through much of the Winchester pack. The kick was missed leaving the score at 11-12. Winchester immediately returned to the Guy's end of the pitch and, with the Guy's backs caught off-side, kicked a penalty to lead the half time score 11-15.

The second half was played by Guy's with the wind at their backs and led to a long period of dominant possession. Handling confidence improved considerably and after a long period of pressure and two missed penalty kicks, Breeze

sped across in the corner to nose Guy's in front for the first time in the match. Guy's dominance continued through most of the second half, aided by long and sensible kicking from Docker. The pressure culminated in a try for the No 8, B J Challacombe, who was driven over the line by Wayne Llewellyn who also converted the try, leaving the final score: Guy's 23, Winchester 15.

All in all, this was a satisfactory performance by the side and augers well for the cup. The side has been particularly strong on the ground this season, and in this match showed that they could achieve abundant position from the front and tail of the line-out against bigger opposition. In the second half particularly, the team showed that with good scrummaging technique, they could move a larger pack off the ball. However they may not be able to give all opponents a 12 point start and get away with it.

Team: N Rose, R Breeze, J Worth, N Baker, G McClellan, R Docker, R Jasingham, G Tsolakides, B Stanhope, M Sear, C Beardmore, E Barrio, W Llewellyn, R Cunnington, B Challacombe, G Ryan.

SJC

Guy's 1st XV v Blackheath XV. 19 Dec. Won 48-22.

Guy's eventually emerged as comfortable winners in the world's oldest fixture, played at Honour Oak Park on 19 December. First played in 1896, it remains the longest series between two clubs.

In a free flowing and expansive match, Guy's got off to a flying start with a first minute try by P Gush, following a run by R Breeze, after Blackheath had speculatively kicked ahead. N Davies converted to give Guy's a 7-0 early lead. Then followed a controlled period due to the dominance of the smaller and faster Guy's pack. The backs were first to the loose ball and were quickly aided by the mobile front five. This led to further well-constructed and finished tries by R Breeze, N Davies, R Docker and a pass by N Davies to give Guy's a 27-5 first-half lead.

Following an early Guy's score in the 2nd half, they then failed to convert more pressure into points. With the game looking dead, Blackheath then scored three times in rapid succession to bring the match within two scores at 34-22. Guy's once again lifted their game and finished with three more good tries to give them a comfortable 48-22 victory.

If Guy's had taken all their chances and the final pass had gone to hand more often, then the score could have been more impressive still. The referee contributed to the free-running game and played the advantage law well on occasion.

Team: M Seare, B Stanhope, G Tsolahides, R Llewellyn, W Challacombe, W Llewellyn (capt), G Ryan, R Cunnington, R Docker, N Davies, P Gush, A Jones, J Wath, R Breeze, M Rose.

BJC

Rugby: 4th XV

Guy's 4th XV v Raynes Park. February 6. Won 21-19.

The 4ths staged a remarkable comeback in this match just when the opposition must have thought they had wrapped it up. As Guy's fell behind early on to an unconverted try, Raynes must have been hopeful of a good result.

Before half time, Raynes Park scored another seven points for a 12-0 lead at the interval. With 12 minutes to go in the

game, they extended the lead to 19-0 with another try. However, Guy's didn't fold and were looking for a consolation try. They nearly got it when Davies pounced on a loose ball from the back of a Raynes Park scrum, but it was not to be. Minutes later Morgan did score and Guppy converted.

From the kick-off Guy's charged upfield but were halted when Raynes were awarded a scrum on their own 22. Gibson won it against the head, Davies released the backs to set up Lewis who scored in the corner. Guppy converted, and soon after the restart he was kicking another, winning, conversion after Lewis had tiptoed down to the touch-line to score under the posts having outpaced the defence. With the last kick of the game Raynes Park missed a potentially match-winning penalty to give us victory.

Team: Popplewell, Gibson, Lams, Blunden (capt), Eddy McDonald, Morgan, Davies, Guppy, Lewis, Osborn, Goodwin, Ekeowa, Zippy.

M Blunden

Guy's 4th XV v Purley. February 13. Won 34-0.

Purley may have had the weight advantage in this match but they could not contend with a Guy's team which showed superior handling, supporting and rucking play as the 4ths recorded their largest victory for more than two seasons.

From the very start Guy's put the opposition under pressure and eventually they were rewarded with a try when Simpson forced his way over the line. Purley then put Guy's under some sustained pressure but the home side held out, and as the interval approached Guy's scored twice—a try in the corner by Ekeowa and a 20 yard charge by Eddy. Dave Guppy converted the third try for a 17-0 half-time lead.

Purley started the second-half with a lot of determination but again found the Guy's defence solid. Then, mid-way through the half, Guy's scored through Goodwin and then through Davies straight from the restart to finish the match off. Tim Lloyd converted the Davies try and then in the last seconds scored a try himself to wrap up an excellent match for the entire team.

Team: Osborn, Morgan, Lams, Blunden (capt), Eddy McDonald, Simpson, White, Davies, Guppy, Ekeowa, Lloyd, Goodwin, Gibbons, Probert.

M Blunden

Rugby: St Thomas's 2nd XV

St Thomas's 2nds v Royal Free 2nds. January 27.

On Wednesday 27 January the first round of the Hospitals Cup A (2nd) was played. In the St Thomas's 2nd side, led by Simon Bailey, several defectors from the Guy's Saturday sides could be seen. The Free, perhaps because of already having been knocked out of the main Hospital Cup competition, brought with them many supporters full of beer and constructive criticism for the referee and place kickers of both sides.

A close first-half saw neither side close to scoring tries, but Ed Hughes managed to convert a long penalty to put the Thomas's side ahead.

The Royal Free quickly replied with a penalty early in the second-half to level the score. However, firm Thomas's pressure held them pinned down for most of

the half in their own 22. From a high attacking Gary Owen from Hughes it looked like Thomas's must score but suddenly the tables were turned and the Free broke out leaving our centres clutching at air. It seemed a certain score but a lightning chase and crunching tackle by winger Ugo saved the try. One minute to go and the scores still 3-3. Thomas's had a five metre scrum at the Free try line. An enormous drive by the Thomas's pack forced the Free to concede a penalty by collapsing the scrum. Another scrum was opted for and this time there was no mistake as No 8 Peter Davis went over for the try in the last play of the game. A good evening was had by all with perhaps the exception of the Royal Free skipper who may have had a gin too many!

Richard Dales

Boat Club—late results

United Hospitals Head of the River Race. 17 February.

Wins for:
Men's 1st VIII
Ladies' 1st VIII
Men's Novice A VIII
Ladies' Novice A VIII
Full details in next month's *Gazette*.

UMDS Football—even later results

UMDS have won the UH Cup second team competition in a game played on Sunday 28 February at Motspur Park. The final score was 3-2.

Deaths

KUMARAPPAN, Sheila died on 27 January 1993 aged 25 following an acute asthmatic attack. She was in her final year, and leaves a loving husband, family and friends.

DAVIES, Laurence died on 14 February, 11 days after his 19th birthday. He was in the first year at UMDS and will be sadly missed by his family and friends.

Computer for sale

386DX 40MHz IBM compatible computer. Colour VGA screen (1Mb card). 4Mb RAM, 105Mb (155Mb with Stacker) hard disk, 31/2" and 51/4" floppy disk drives. Comes with mouse and over £1000 software. Only 6 months old—21/2 years warranty remaining. Comes boxed. Price £900 ono. Excellent condition. Tel (071) 403 8187—can deliver within reason.

Old Gazettes available

The following *Guy's Hospital Gazettes* are available to any person, library or department who might want them:

1950-51 bound with index.

1952-57 complete sets with index. Unbound.

1958 Nos 1813-35 with index. Unbound.

1959 Nos 1842-44 and 1848-50 plus index. Unbound.

Please contact Hujohn Ripman at Red House, Sproughton, Ipswich, Suffolk IP8 3AT for further details.

Room to let

In flat by Tower Bridge. FGCH, quiet block. £65 per week inclusive. Tel (071) 407 3177.

Theatre tickets

Nurses and students, senior citizens and hospital staff can now book concessionary tickets to see a production of *The Invisible Man* at the Vaudeville Theatre in the Strand. Tickets priced £8.50 may be booked through the box office, tel (071) 836 9987.

Caption competition

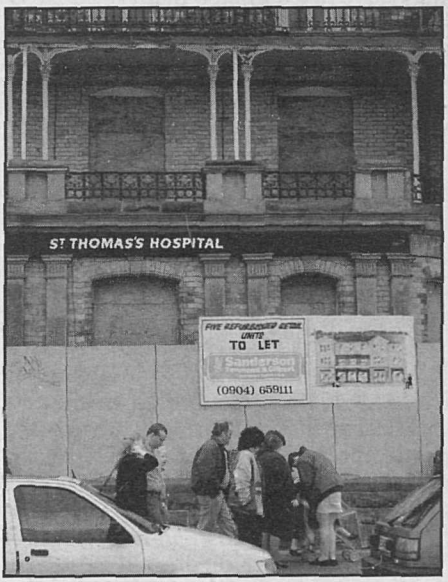
Last month we mentioned Dr Bridges as the winner of the £10 prize, but ommitted the winning caption. His original, dating before the publication of the Tomlinson report was:

One of the three teaching hospitals has to go, so if we place the detonator just here...

He has since given the matter more thought, and further justified the award by coming up with:

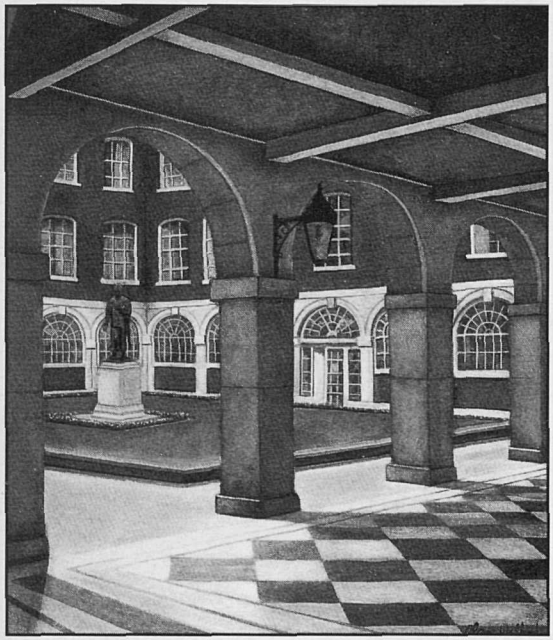
Mrs Bottomley says its all community care now. So with the hospital closed, why shouldn't he be treated on the pavement?

Many thanks to Saikat Banerjee for the photograph, which I have now managed to use in four issues. So you can see that it pays to provide material for the *Gazette*.



Guy's Hospital
MEMORABILIA

Unique items available only from the Gazette



These high quality cards depicting the Colonnade are left blank inside for your own message. The original oil painting by Clare Walford, a recent graduate, was presented to Dr Scott in appreciation of his 20 years as Gazette Committee Chairman. Cards are available in packs of 10.

Price £10 per pack of 10 + £1 p&p

To: The Manager
Guy's Hospital Gazette
Boland House
St Thomas' Street
London SE1 9RT

I enclose a cheque/PO for £ .....
NAME: .....
ADDRESS: .....
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Please make cheques payable to Guy's Hospital Gazette

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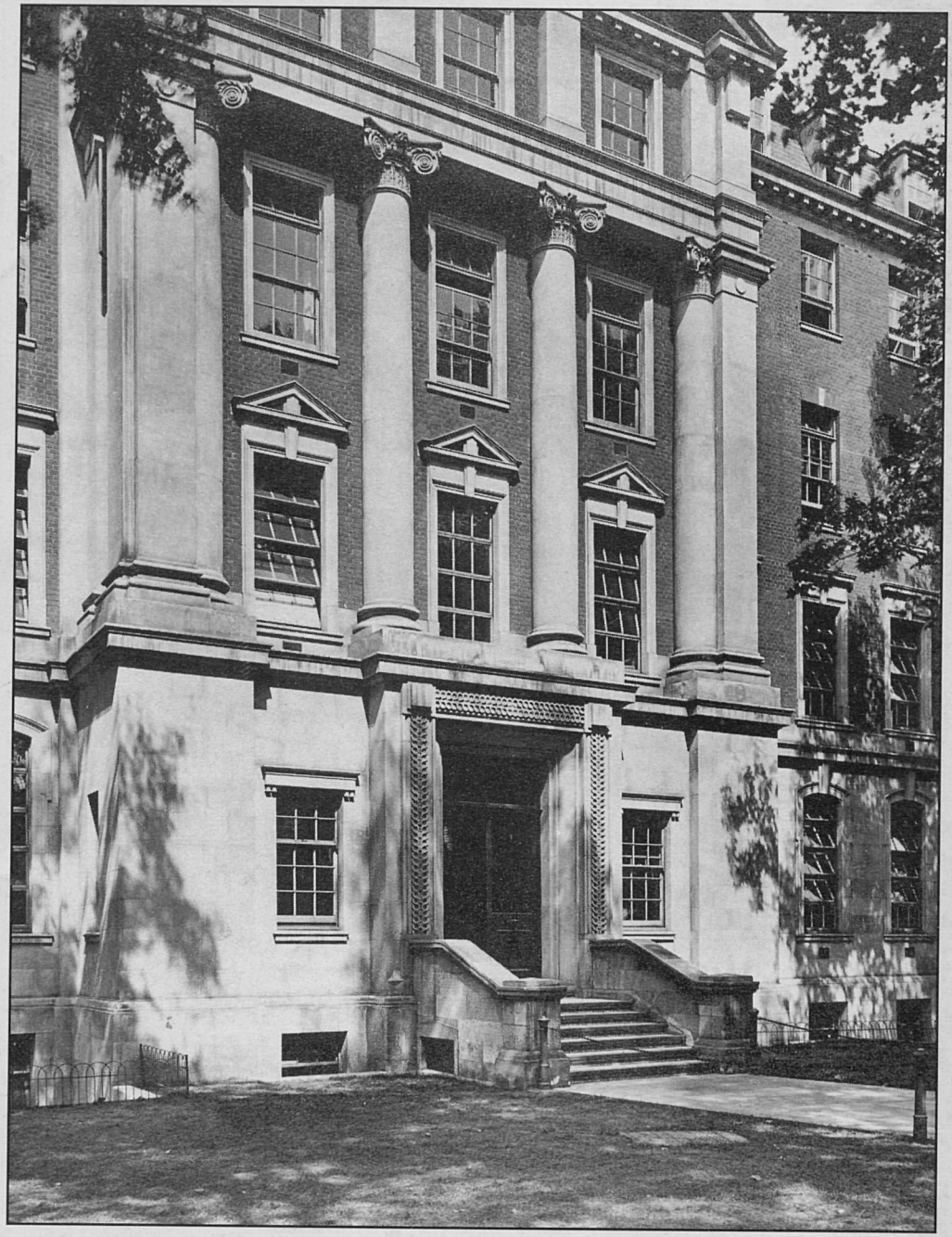

GUY'S

HOSPITAL GAZETTE

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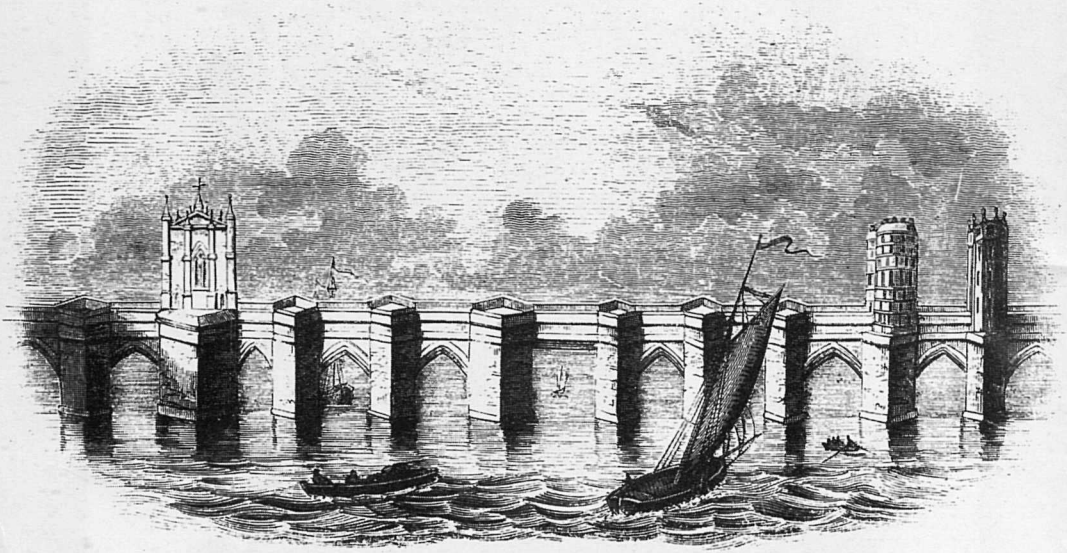
April 1993

- Electives—opportunities at Johns Hopkins
- Dr Hugh Saxton—an appreciation
- Sport—Guy's and UMDS successes



London Bridge, 1209.

CONTENTS

90 **Passim**

91 **Letters**—defending Guy's, and McDonald's

94 **News**—Joint Trust, no smoking policy

96 **Johns Hopkins**—elective appointments

98 **Dr Hugh Saxton**—an appreciation

100 **Médecins sans Frontières**—career alternative?

106 **Work and Play**—Dr Pitt-Payne continued

114 **Reviews**—video

115 **Obituaries**—Sheila Kumarappan, final year student

116 **Nursing Notes**

118 **Physiotherapy Notes**

121 **Sport**—Guy's and UMDS successes

132 **Classified and Announcements**

UMDS Guy's
28 APR 1993
Wills Library

Guy's Gazette

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The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

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Passim

In the last issue, I mentioned the formation of the new joint Guy's and St Thomas's Trust. One does not envy their task of having suggestions for the rationalisation of hospital services ready in as short a time as six months. Members of the Trust management board are currently familiarising themselves with the workings of the 'other site', be that Guy's or St Thomas's. Six months may seem an awfully short time for restructuring an organisation as large as the new Trust, and this may lead to some unavoidable pitfalls. There is, however, one main advantage of producing these proposals rapidly, and that is the removal of uncertainty. At least before the year is out, staff and students should be able to have an idea of the framework within which they will have to work. It will provide some idea of the goals to achieve and the objectives to be aimed for.

Change is something that has become one of the features of life today. There appear to be two conflicting views related to change; firstly reflecting the positive aspects in the saying that 'a change is as good as a rest', and secondly the identification of major changes, even if they are beneficial, as 'life events', with their associations of increased morbidity. I believe the key to planning change in order to emphasize the positive aspects is information. The situation is akin to giving patients a realistic expectation of the procedure that they are about to undergo. Those who have had things explained pre-operatively tend to be happier post-operatively.

This then brings me to my last Passim, before I hand over the editor's chair to Romila Bahl. Romila is in her first clinical year, and will, I am sure be able to steer the *Gazette* successfully through the months ahead. I hope that I have been able to serve you, the readers, well. It has been a great privilege to edit this journal, a task that has its demands, but which provides a source of enormous satisfaction.

With the Oscar's ceremony very much in mind, it only remains for me to thank those who have helped and supported me in this post: Dr Knight, for his excellent chairmanship of the *Gazette* Committee, Margaret Flanders, for every aspect of the office management, all the *Gazette* staff and contributors . . . my agent . . . my immediate predecessors . . . my mother . . . the printers . . . and, of course, the computer, for working . . . most of the time.

Championing Guy's

Dear Sir,

In the Crypt beneath the Chapel here at Guy's Hospital lies the tomb of a man with vision. Is Thomas Guy's vision dying?

I have been carefully following the negotiations and consequent rumours that have developed over recent months concerning the proposed merging of Guy's and St Thomas's hospitals. I have been waiting to see who would defend and champion Guy's. No one has emerged and I am left wondering if there will be no struggle for survival. Further management related developments (the appointment of St Thomas's Chief Executive rather than Guy's to head the joint Trust) seem to stack the odds further against Guy's. It now seems increasingly likely that the Guy's 'flagship' will soon slide beneath the ocean of compromise, with no more than a ripple. With the greatest of respect to all concerned we at Guy's seem to be taking to the deckchairs even as the water laps around our ankles in Canute-like style.

It is an unfortunate consequence of the competitive situation for survival between Guy's and St Thomas's that to support one, inevitably seems a slight on the other. The merits of closing either seem dubious to me. On a practical level, no one seems able to explain just how all the services of one site can be absorbed by the other. As one astute GP acknowledged in a television debate recently, 'No amount of money in the community, however welcome, will facilitate appendicectomies on the kitchen table'. Talk of endless empty beds on a political level is hard to justify on the ward.

Having spent nearly five years at Guy's I feel passionately that it is a place and a people worth saving. What will become of Thomas Guy's legacy? I sincerely hope that Guy's will show a little more effort, for both its founder and its future, than has so far been manifested.

Yours faithfully,

SIMON BARKER
Boland House
Guy's Hospital

Elective travel

Dear Sir,

This letter is mainly for those students who are scheduled to embark upon their electives later on this year, and in fact for anyone who is thinking of travelling by air.

There is an organization that is dedicated to providing the cheapest airfares and also offers significant discounts on car hire, hotel fees, ready-made tours and special round-the-world fares. The organization is called *WEXAS International* and some of the prices they have to offer are very good value indeed, (round the World tickets start at £695).

All these benefits can be obtained for the duration of a year at a cost of just £27.71. Insurance and cheap travel (including a year round policy for less than £100) can also be purchased from *WEXAS*. This is particularly useful for students who are thinking of travelling to numerous destinations or far away lands. Cheap airfares, insurance packages and tours can all be booked from the same organization, The member is also provided with a discount card for car hire and hotel bookings. These benefits should

help to smooth things when it comes to elective travel.

In addition, membership entitles the member to receive the award-winning *Traveller* magazine, travel brochures and newsletters.

I thoroughly recommend students look into this package. As a special concession, the director of the company is offering a one-month trial membership for those interested. An information pack containing the above brochures and magazines will be sent to applicants and they will be given a month to make up their minds.

For more information please contact WEXAS on (071) 589 3315 or I can be reached via the Boland House pigeon holes.

Yours faithfully,

ABBI LULSEGGED
BMA Representative
Boland House
Guy's Hospital

In defence of McD's

Dear Sir,

As the one who did the deadly deed, I cannot share Donald Fry's somewhat hysterical view that the arrival of McDonald's at Boland House spells the end of the world, or that any hospital need feel embarassed at leasing surplus property to this particular company, or that there was no consultation.

Food snobs sneer at 'plastic food' but never seem to compare it to what it replaced or what it competes against. Personally, I rarely eat burgers of any description but when I do, like millions of others the 'Big Mac' offers value for money and is served in generally clean surroundings by well trained staff—to the best of my knowledge its ingredients do not include plastic.

As far as I know, the Church of England does not object to commercial development opposite or adjacent to its churches—in fact the Chapter House at Southwark Cathedral has been converted to a pizza restaurant without even one thunderbolt. Thomas Guy, himself a trader, would I am sure have approved of the commercial advantages arising from the deal.

For some on duty staff, the arrival of McDonald's and the Piece of Naan provided a welcome added choice to what is provided by the hospital. I stay overnight at the hospital, usually every four nights and make a point of an evening walkabout. The ratio of hospital users in McDonald's to the in-house service in the Nurses Dining Room is generally two to one in favour of McDonald's. Moreover what is on offer from us is also fried. I am not sure whether Mr Fry wants free board and lodging but prices in our canteens are subsidised and this subsidy is paid for by the charges to the patients. I personally consider that we should all pay in full for our food and that salaries should reflect this cost. There is no coercion to eat anywhere—many staff still bring in their own food or prefer to go off site, many to some well known pubs!

With regard to advertising, there is a recession in the high street which means heavy discounting and special offers—why shouldn't our staff take advantage of these marketing initiatives in food? What is the difference between coupons for food and coupons for suits or travel?

Finally we come to the *Health of the Nation* and the suggestion that hospitals should lead by example. Where does this argument end? Ration books, the closure of fish and chip shops, public houses, prohibition on red meat, cream, cheese and white flour? Should all smokers be dismissed—followed by any person who is overweight. This, Mr Fry, leads to a puritan culture that verges on fanaticism. Freedom of choice, education and tolerance are the ingredients for a healthy nation. We eat too much, but whatever diseases are caused by over-indulgence, the finger should perhaps point at the brewers rather than McDonald's. I feel also that if we were all leaner we would be equally meaner and subject to more depressive ailments just as costly to the NHS.

In conclusion, I apologise to those who were inconvenienced by McDonald's, but in place of a costly subsidy on what was a pretty tacky restaurant rarely used for more than three hours a day, five days per week, there has been an investment of nearly £1 million to provide a bright, fast food operation, open from breakfast until midnight, seven days per week.

In place of subsidy, the hospital recieves rent and does not incur the capital charges on the building. It also enjoys a crèche, thanks to a generous donation from our tenant.

In the consultation process, considerable attention was given to the aesthetics of the conversion and, notwithstanding the sign which will go when the bridge is re-aligned, McDonald's have not intruded on the area, nor is their operation any more disruptive to residents than events in the basement. The tenant is also employing 60 staff where we employed six.

To those who abhor the commercialism that has replaced the fantasy of unlimted funding, there are worse excesses than a fast food bar to be offset against a £50 billion PSBR. The rent may only end up paying for the losses on the Spit next door or the cost of the accomodation above. It is nevertheless real money that would otherwise come from clinical budgets. There would appear to be more customers in a day using McDonald's than we manage to serve in a month. I rest my case with a plea for objective assessment not emotional rhetoric.

Yours faithfully,

KEN WOLLASTON
Commercial Services Manager
Guy's Hospital

No smoking policy at the hosptial

A no smoking policy has been in effect at St Thomas's from March 10, National No Smoking Day, applying to all UMDS staff and students. Smoking is only allowed in designated areas and the sale of tobacco on hospital premises has been banned. A similar policy is soon expected at Guy's, the current policy involves no smoking areas.

The policy aims to encourage a healthier environment, to help smokers who wish to give up, to set a good example to the public and to promote awareness of the effects of smoking on health. UMDS intends to extend the no smoking policy to the medical school, as an intial step to ensure that medical school policies are compatible with hospital policies.

Sir John Prideaux memorial service

A memorial service was held on Friday 12 March in Southwark Cathedral to mark the death of Sir John Prideaux. Sir John, who died on 7 January this year aged 81, was Chairman of the National Westminster Bank from 1971-77. His chief interest outside the City was St Thomas's Hospital, for whom he served as Treasurer, Chairman of the Special Trustees and as a member of the UMDS Council of Governors. He was responsible for many of the structural improvements made to St Thomas's, and was knighted in 1974.

The New Joint NHS Trust

Virginia Bottomly, Secretary of State for Health, responded to the Tomlinson report, during February, by announcing her plans for the future of London's hospitals.

The Department of Health has asked the new Guy's and St Thomas's Trust board to suggest proposals, within six months, for consolidating services on one site. The report *Making London Better* states that any such proposal should take into account any possible uses of the alternative site.

Mr Tim Matthews has been appointed as prospective Chief of the Joint NHS trust of Guy's and St Thomas's Hospitals. He joins this post from his previous position as the Chief Executive of St Thomas's Hospital Trust.

Medical students elective prize

The British Association of Forensic Medicine is offering a prize of £200 for the best written report on a project in forensic medicine undertaken during an elective period in the 1992-93 academic year. The successful candidate will have the opportunity to spend a month in Vancouver in the department of forensic medicine.

Further details may be obtained from Professor M A Green, Department of Forensic Pathology, The Medico Legal Centre, Watery Street, Sheffield, S3 7ES. The closing date is 30 November 1993.

Dental awards cermony

The UMDS dental awards ceremony will be held in Southwark Cathedral on Thursday 13 May, at 3.00pm.

New R&D Director

Professor Ian Cameron, is to become the Director of Research and Development for the SE Thames RHA.

His role will be to provide leadership and direction for any research or related activities, that are funded by the RHA. The plans of the region will be part of the national framework, as outlined in *Health of the Nation*.

Professor Cameron will continue with his clinical teaching and research activites as Dean of UMDS.

Medical staff required

The youth development charity Raleigh International (formerly Operation Raleigh) urgently requires volunteer medical staff for three month expeditions to countries including Siberia, Guyana, Namibia, Chile and Zimbabwe. The volunteers will work closely with small groups of young people on a variety of projects, depending on the country involved.

Doctors and nurses should apply to: The Medical Coordinator, Raleigh International, The Power House, Alpha Place, Flood Street, London, SW3 5SZ. Telephone (071) 351 7541.

Guy's Hospital — 250 years

Have you ever wanted to know more about the history of Guy's? What was student life like in the nineteenth century medical school? What happened in the Residents' Plays of the forties and fifties? How about nursing, midwifery, the Wills Library? Or the early days of X-rays?

This 240 page, illustrated paperback gives a history of the achievements in every field of Guy's life for the past 250 years, and is available for only £2.95, including postage and packing, from the Gazette office. The book makes an ideal gift, and only a limited number is available.

Please send cheques or postal orders, made payable to Guy's Gazette, to Guy's Hospital — 250 Years, Guy's Gazette, Boland House, London SE1 9RT.

The Johns Hopkins Elective Experience

Bobby Prasad talks about his time spent in Baltimore

I landed at Baltimore-Washington International Airport, after having just spent two weeks lazing around Greenwich Village in downtown New York doing everything but work. Doing something vaguely academic was quite far from my mind—after all, this was the *start* of my four month elective, and there was surely going to be plenty of time to do lots of work.

I was fortunate enough to be met at the airport by a close friend, who whisked me away in a seriously dodgy-looking taxi to Hopkins. I had come down in the world somewhat after having been picked up at JFK by another friend, but on that occasion in a Lincoln Continental stretch limousine. Not a good start, I thought! I had heard some reports about Baltimore being a violent city full of socio-economic deprivation and drugs-related problems, but the first 20 minutes of the taxi journey seemed relatively pleasant. Then, all of a sudden, we were in a ghetto and signposts pointed to Johns Hopkins a half-mile away. The reality of the situation struck me like a bolt out of the blue—the stories had been true after all.

As we arrived at Hopkins, the incongruity between the impressive campus buildings and the rough, run-down surroundings became apparent. The accomodation block was similar to Wolfson House, although the rooms did have air conditioning—quite a relief given that daytime temperatures were above 80 degrees Farenheit.

I was then given a quick tour of the hospital and the excellent sports facilities--not bad, I thought. The restaurant was more in keeping with a Marks and Spencer food hall than with the Spit, yet the prices were half--even better!

Over the next few days I settled in and visited the 'legendary' Baltimore Harbour which was reasonable but seemed to be the only thing to do in Baltiomore. By now I'd got my ID—an essential requirement for getting around the hospital due to the tight security. Starting work in the Department of Paediatric Cardiology I was rather overwhelmed by the degree of affection and friendliness shown to me by both staff and other students. It was a life of first-names, doughnuts at morning ward rounds, popcorn at afternoon case

presentations, unlimited 24-hour access to all the facilities of the department including free photocopying. All in a world-renowned department!

By this stage I had found the Hopkins library, and was staggered to learn that as a Guy's student I could borrow up to 99 books at any one time—would the Wills ever trust us with so many? Would a Guy's student ever take out 99 books?

The first week was spent discovering the hospital by day but alas the evenings were getting to be a bit of a bore. To leave the campus you needed to call a cab, but the tricky part was finding somewhere you could go. It was then that fate smiled upon me. I met some elective students from other American colleges. They were familiar with both the Hopkins and the Baltimore social life and introduced me to a number of lively Hopkins medics—from then on there was seldom an evening with nothing to do. I got to see the other side of Baltimore, beautiful suburbs, lovely restaurants, great bars and friendly night-clubs.

Meanwhile, the work was getting more involved. It was fascinating to see such a wide range of clinical cases, and to be in charge of a certain number of patients for the cardiology team. I was required to know every detail of the history and management of all of my patients. Often they would be the only known cases, so a great deal of my time was spent in the library researching them. It did however make me feel like I was a real member of the team and was definitely an invaluable experience.

Weekends were always free and I spent them travelling to Georgetown or Washington DC and flying. One of the beauties of the States is that flying lessons are a great deal cheaper than in England and I would definitely recommend them to anyone. Piloting an aircraft over Baltimore was one of those experiences of a lifetime.

Overall, I would say that Hopkins is a great place for an elective. It is an institution that is at the forefront of medicine, with an impressive array of academics and facilities. Moreover, they treat Guy's students very well and offer them virtually all the privileges they give their own students. The best advice for having a good elective at Hopkins (and probably anywhere) is to get involved. I certainly did and had an extremely useful and enjoyable time both academically and socially.

Bobby Prasad

Dr Hugh Saxton

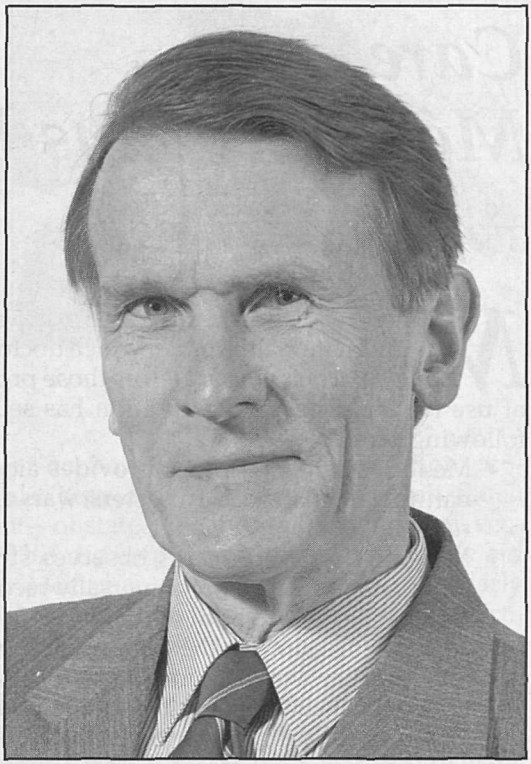
An appreciation of an influential Guy's radiologist

November 27, 1992 saw the end of a career spanning 30 years at Guy's Hospital. Over this time enormous changes in the speciality of radiology have taken place and also in the wider context of the character and running of Guy's Hospital. Hugh Saxton has played a central role in both the evolution of the Department of Radiology and in the way Guy's Hospital has changed. He, as much as anyone, has maintained a continual concern about maintaining the quality of service to the patients in the care of Guy's.

He trained as a radiologist at St Mary's, UCH and the Westminster Hospital and, for a short while, was a consultant in Cheltenham. His appointment at Guy's was the beginning of an illustrious career, promoting his special interest in uroradiology. Guy's has for a long time been a home for the special units of adult and paediatric nephrology and urology with special interests in bladder dysfunction. A very productive link was developed by Hugh Saxton between these departments and the Department of Diagnostic Radiology.

Over the last three decades new imaging technology has developed rapidly, with vascular and interventional procedures, computed tomography, ultrasound, nuclear medicine and magnetic resonance imaging. Hugh, however, never lost sight of the basics of radiology, although in recent years he became more and more attracted to, and skilled in, interventional procedures, the therapeutic side of radiology. A superb teacher in film interpretation he also was able to guide the inexperienced to perform interventional procedures safely and successfully. The weekly clinico-radiological meetings, which he chaired with the urologists and nephrologists at Guy's, were always one of the week's teaching highlights. Hugh Saxton has the skill of thinking fast on his feet and could usually keep well ahead of the clinicians who would from time to time try to catch him out. A most efficient worker, he published papers, reviews, chapters for books and was for a time editor of the *British Journal of Radiology* and also on the editorial boards of *Urologic Radiology* and the *Journal de Radiologie*.

His gift for quick thinking and effective communication led at first to posts in the College of Radiologists, including examiner for the final part of the Fellowship, followed by membership of a number of committees in the Region, the Department of Health and in the Medical Research Council. In 1984 he



became Chairman of the Academic Board of the United Medical and Dental Schools and during this time he was also Chairman of the Hospital Medical & Dental Committee.

With the changing management scene and the introduction of the directorate system based on the system pioneered by the Johns Hopkins Hospital, doctors were encouraged to become more involved in key management decisions. Following on from Professor Cyril Chantler's pioneering years Hugh succeeded him as Chairman of the Management Board. It was during his time as Chairman that the Conservative government introduced the Health Service reforms, introducing a market element to provision of services. Hugh felt strongly that Guy's would be at an advantage to be one of the first trust hospitals and he helped steer Guy's to its successful application for trust status.

In spite of the enormous management pressures he was still able to take a very active part in the Radiology Department, including an on-call commitment.

On his last working day, characteristically he persuaded his colleagues to arrange a farewell seminar entitled 'Devilled Kidneys' and this was followed by a buffet supper which was held in the Robens Suite. The very large number of radiologists and radiographers attending who had trained in the department was a tribute to Hugh and an expression of how much people felt they owed him. A marvellous send off to a man who has given so much to Guy's Hospital.

Dr A J S Saunders

Careers: Médecins sans Frontières

The Charter

Médecins sans Frontières is a private organisation which operates internationally, and in which doctors, nurses and other health workers participate, as well as those professional groups which might be of use for the task the organisation has set for itself. They subscribe to the following principles:

- Médecins sans Frontières provides aid to people in need, to victims of natural and man-made disasters, wars and civil wars, irrespective of race, religion, ideology or politics.
- Médecins sans Frontières observes strict neutrality and is completely independent. Based on universally recognised principles of medical ethics and the right to humanitarian aid, Médecins sans Frontières demands complete freedom in the performance of its task.
- The members, volunteers and staff of Médecins sans Frontières observe the medical code of conduct and maintain complete independence from any political, religious or economic power.
- The members, volunteers and staff of Médecins sans Frontières decide for themselves whether the risks and dangers of the work are acceptable and do not demand any compensation whatsoever for themselves or claimants, aside from that which the organisation can give them.

Introduction

The charter sets out the guiding principles to which all members of Médecins sans Frontières subscribe. Médecins sans Frontières was established in 1971 by three doctors. Since then the organisation has grown substantially. Last year over 2000 people worked in the field, 25 from the UK. The annual budget was approximately £100 million.

It is a truly international organisation, with operational sections and branch offices in 12 countries. Volunteers from 45 nations worked in 58 countries from Albania to Zaire last year. Six European organisations operate under the joint name of Médecins sans Frontières. Each is mutually independent, and has

complete autonomy over the projects it selects. Co-ordination and co-operation do occur for large projects however, for example in providing emergency aid to Kurdish refugees (the biggest operation in the history of Médecins sans Frontières). An international office, representing the organisation throughout the world has been set up in Brussels. The UK office was launched in November 1992, and is chaired by Lord Owen.

Sudan, 1991

Médecins sans Frontières takes on both long term rehabilitation programmes, such as in Uganda, and also provides emergency medical relief such as in Yugoslavia. It is independent—of states, institutions and political, economic and religious influences. This distinguishes it from comparable aid agencies such as the Red Cross. Médecins sans Frontières is particularly concerned about the misuse of humanitarian aid by politicians and governments to enhance their 'public image'. Witness the arrival of the Americans in Somalia last year. Jacques de Milliano, Director of Médecins sans Frontières Holland, has said that 'humanitarian aid provided on political grounds leads to chaos'. One of its basic tenets is that everyone has a right to health care. It strives to provide medical aid to populations in crisis, whether through wars, natural or man-made disasters. International law,even, on occassions has been disregarded. National borders have been crossed illegally to reach threatened populations in, for example, Afghanistan and Somalia. This independence is a product of its financial autonomy. Médecins sans Frontières is largely supported through private donations and gifts, although it does receive some money from certain governments and international organisations such as UNICEF.

Projects

Aid is provided as a response to a request for help. The request may be from a resistance group or local organisation, or it may come from governments or international organisations. An exploratory mission is initially deployed, usually consisting of two experienced members, to evaluate the situation and its medical, nutritional, and sanitary needs. Teams are then dispatched, their

composition depending upon the particular requirements of the operation. In 1985 an emergency intervention unit was created in Belgium, enabling a response to disaster within 24 hours.

The nature of work is dependent upon the situation. In the event of armed conflict, medical teams composed of doctors, surgeons, anaesthetists, specialised nurses and logistical personnel are sent out with equipment to render them immediately operational. They will be working at the sharp end, in the short term, dealing with the immediate medical needs of the affected population. Médecins sans Frontières also supports long term projects where training and rehabilitation of health services are the key aims, such as in Cambodia.

Cambodia

Cambodia has been ravaged by conflict for almost 20 years. The bloody and notorious regime of Pol Pot's Khmer Rouge was followed by more than 10 years of civil war between them and the Vietnamese and Soviet-backed Hun Sen government. This war has mutilated and handicapped over 100 000 people.

A fragile peace has existed since Autumn 1991. The spectre of unexploded mines still remains however. The Khmer Rouge deliberately targeted civilians by mining rice paddies, paths and roads, in order to stop agriculture. Most of the victims have been peasants, rice harvesters, and children. The tiny plastic mines drive dirt and shrapnel, invisible to X-rays, deep into the tissue where infection spreads fast.

In 1991 Cambodia had 8.5 million inhabitants and 35 000 amputees, many destined to become beggars and criminals. The medical system that remains after 20 years of instability cannot cope. There is a mortality rate of 170 per 1000 for the under fives, high rates of TB and only one in eight

The war in Cambodia has handicappedsome hundred thousand people. This photograph shows a rehabilitation centre where amputees make their own artificial limbs.

amputees has an artificial limb. It can take hours to reach the nearest hospital, since they are so few and far between. The health care that does exist is largely private. Even within the public system, patients must still pay for their own medication. Some drugs used to be provided by the USSR but this no longer occurs. Medical staff in general are paid very poorly, typically about £15 per month.

Médecins sans Frontières started their operations in Cambodia in 1989. Aid programmes are underway in Svay Rieng, Kampot and Beantey Meanchey. Bruce Laurence is an English doctor who has just returned after 14 months there. He lived with seven other Médecins sans Frontières staff in a large house. They had electricity for a few hours each day, but no running water. The authorities and the local population had given them a generally good reception, although there was a degree of resentment from medical staff. He concentrated on staff training and co-ordination of health services; there was less work as an actual doctor. He described the work there as not stressful, but often frustrating. Progress was slow. The team worked a five and a half day week and evenings. Work became their life, although it was, 'a holiday after being an SHO in paediatrics'. Self-motivation was important. Dr Laurence described his year as one that had not been wasted. He is continuing with Médecins sans Frontières, despite uncertainties about his career prospects.

The main activities of Médecins sans Frontières in Cambodia are aimed at improving and supporting public health care. They have distributed drugs and medical supplies, refurbished dilapidated medical facilities, and embarked upon training of local health workers. Basic improvements of drinking supplies and sanitation have been accomplished, and vaccination programmes started. Rehabilitation centres have been set up where the handicapped make their own artificial limbs. The situation in Cambodia typifies much of the less glamorous work of Médecins sans Frontières.

Entry Requirements

To work for Médecins sans Frontières you have to be a qualified doctor with at least two years experience, some of which must be overseas (electives count). All medical specialities are represented in the organisation, although they especially require anaesthetists, paediatricians, obstetricians and gynaecologists. Experience in tropical medicine is also sought after. Knowledge of a foreign language is required, but the official language of the organisation is English.

Perhaps more importantly you must be a particular type of person. The nature of the work does not suit everyone. A standard project placement lasts for nine months. Self-motivation is required, since there is a great deal of

freedom and autonomy. It can be a strain on relationships, and it is an advantage to be 'psychologically independent'. Very few workers have long term relationships or children.

Volunteers are paid. There is a standard wage of £400 per month. Board and lodging, travel and insurance are all met by the charity. Furthermore, opportunities to spend money whilst on a project are few and far between, and so £400 goes quite a long way.

There is an element of danger and discomfort. Facilities are not ideal. Conditions may be physically exhausting, especially where short term emergency aid is required. Almost every year workers are killed and injured. Some are deliberately murdered, others are casualties of war, still more are killed in road accidents. In 1981 two were jailed in Turkey. Working under the continuous threat of violence, and experiencing atrocities and disasters first hand, all take their toll psychologically.

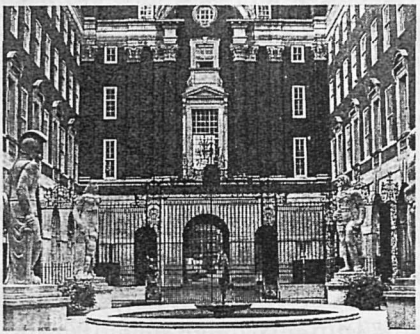
Is it possible to take a year or more off from medicine to work for Médecins sans Frontières, or other aid agencies, without affecting your career? It would seem to pose few problems to those who want to become general practitioners. For those who wish to become hospital doctors the decision must be thought through more carefully. Taking time out can be a setback to a career. Medical work can sometimes be limited in scope, and facilities for diagnosis and treatment are restricted. Surgically the outlook is good. The opportunity to perform more operations is there. The idea of performing aid work is becoming increasingly accepted, and is possibly best done at registrar level. It should also be a deliberate move, however, and not a last resort because no other jobs were available!

Conclusion

Working for voluntary agencies attract thousands of doctors each year. It can be a highly rewarding and satisfying job. It is adventurous, and it can take you anywhere in the world. Médecins sans Frontières provides the opportunity to make a difference to many people's lives, in the short and long term, in a way that is startlingly different from within Western Medicine.

Mark Dayer

"If you need professional help"...



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Treading the Boards

1971 and onwards

The Theatre Club at Guy's was always a very active body of men and women, and I sometimes wondered how on earth they ever managed to get any work done. They used to do things to the Physiology Theatre with scaffolding and planks of wood, creating a floor which extended a third of he way up the theatre. Curtains, lights, and other theatrical devices, totally foreign to my untutored eye, further adorned the set-up so that the casual visitor such as myself got the distinct feeling that here was a place where something theatrical was bound to happen. I had rather gone off the theatre ever since seeing Act Two of *Ruddigore*, when I had had a rather unpleasant experience which I'll tell you all about some other time. Afficianados of Gilbert and Sullivan may recall that this is 'the ghost scene' where all the pictures come to life and then some medieval fellow comes out and sings a jolly song about 'howling night winds where bats fly'—and stuff like that. As doctor to some rather well-known Equity Card holders I have had to mend my ways and I could tell you some really ripping yarns about what I have seen back-stage but discretion must be that better part of valour as I chicken out of that one. Only the 'Vomiting Ballet Dancer' comes to mind; an Aussie roué in over-loaded tights who found that his 'spins' and 'entrechats' came to grief after spending over-long in the local hostelry—also during Act Two of something called *Coppelia*. There was a succussion splash there reminiscent of the swimming pool on the *QE2* during a Force 10 gale. No wonder the choreographer was in such a state when he rang me.

The Dumb Waiter

It was back in the late sixties that the Theatre Club put on a play by Harold Pinter called *The Dumb Waiter*. For reasons already discussed, I never attended these performances but my old friend, Nick Longhurst, now a Consultant Psychiatrist at The Fairmile Hospital in Oxfordshire, had landed a key part in this item—and I felt bound to attend just to see what he'd been up to. It wasn't a big cast as I remember—maybe only two or three players—nor was it terribly long. The ideal play, therefore, for yours truly; although there were others that night. The thought of people dressing-up, making-up, and pretending they were someone else had never really held me in its thrall. However, I went to

support Nick as he did his bit, and he did it very well, but the play puzzled me as I never saw a single dumb waiter. As a schoolboy—and prior to *Ruddigore*—I had only ever been awarded non-speaking parts due to some kind of precociousness which made me something of a liability once I got anywhere near treading the boards. I clapped enthusiastically, though, at the end of the play as what amounted to the curtain separated us from the cast as they took their final bow. Then I turned to the person sitting on my right—and said, 'And what about the dumb waiter then? I was waiting for him to come on and he never did.'

I was favoured with a withering glance, reserved, one suspects, for the most severely retarded, and I carried on living in ignorance. It would have helped me no end if someone could have explained to me that a dumb waiter is a lift which ferries food from one floor to another. One learned something new every day in those times. The original dumb-waiter was an 18th century English contribution to the ameneties of the drawing room. The mahogany dumb-waiter which was introduced in the 1730s, consisted of two to three trays of graduated sizes pivoted on a central system, the legs of which were on castors. The trays usually contained wine and glasses etc thus obviating the need for servants hovering around the guests on social occasions. In the days when servants were noted for making improper use of confidences overheard, the dumb-waiter was a notable asset. A note in the programme to this effect would have helped me no end, and my understanding of the play would have been that much more comprehensive. On a point of information, the dumb-waiter seems to have changed sex in recent times and now food maybe kept on or in a 'hostess' trolley. We had one at home—and it was a bit of a horror because it was the kind of solid object I was always stubbing my toe on. Give a waitress every time—that's what I say!

The Residents' Play of 1971 presented us with no such complications. Rehearsals always started at 10pm at night and went on for two to three hours as we waded through Michael Simpson's excellent script. The plot may not have been quite as complex as it had been in recent years—but it was very funny. I still burst into song from time to time with my patients and sing them a chorus from Dr David Snaffle-Shark's song—which went thus:

'Is your Ego getting tatty?
Is your Psyche wearing thin?
Are your Id and Super-ego far from nice?
Then with drugs and chat and ECT,
A weekly sight of little me,
We'll have you really well in just a trice!'

Colleagues may be surprised that I should sing to my patients but I think it cheers them up a bit on the odd occasion. Besides, it keeps the therapy cases on their toes as they wonder who's seeing who! Many's the time I would sing snatches from *Rigoletto* whilst performing Evacuations of the Retained Products of Conception in theatres late at night whilst serving as an SHO at Farnborough Hospital. *La Donna E Mobile* seemed terribly apposite at two in the morning. Translated, that song would never pass muster by the feminist standards of today. Poor old Joe Green would have had a lot to answer for calling a song 'Woman is a Fickle Jade'!

I could always cheer up the bleeding patient in the first trimester with such phrases as, 'Why—I was a Threatened Miscarriage once, and look at me now'! This was a far cry from the spotty Herbert who sang in the Bromley Music Festival of 1969 before no less a personage that Olive Groves, herself a famous singer in her day. The sight of me in Prince of Wales check three-piece suiting with a yellow paisley bow tie attempting one of the great arias in the operatic repertoire seems laughable to me now. I had vowed not to sing in public again after that humiliation but fate stepped in and gave me a song in the medley at the end of the show—'When this bloody ward round's over'—and for six nights on the trot I was to get the kind of encores I could have only dreamed about. How on earth we managed to do a day's work—and sometimes a night's too—and still perform on stage is still something of a mystery to me. On the Saturday morning after the last performance, a recording was made in the Residents' Lounge and this was turned into a hundred LP records which sold at a pound each. I still have two of them now. My sister-in-law-to-be and her husband came to the Friday performance. What they were expecting, I was not to know, but afterwards they expressed considerable surprise at the professionalism of the whole play having expected something along the lines of a review.

Obstetric Emergencies

But time was moving on—and so was I. There was the tempting offer of the RMO job at King Edward VII Hospital for Officers in London. £3000 a year and a house, but I was much more attracted to the post at Farnborough Hospital, where there were 2,300 deliveries a year at the time and the chance of a hands-on experience of a lifetime. First, though, a wonderful holiday in the West Country with my fiancée. We stayed on The Earl of Devon's Estate and the sun shone every day. Jacqui's grandmother's cooking was rough and ready, although she had a very pleasing way with custard and this was poured over every sweet course going. My full registration came in May 1971 and I took up residence at Farnborough Hospital whilst Jacqui became Night Sister

on the Burns Unit at Stoke Mandeville Hospital for three months. In the next six months I would be taken through just about every dire emergency possible in obstetrics—or so it seems now—and when I look back I am surprised at some of the things that happened. There was the lady with Addison's Disease who came in having suffered a partial miscarriage. I put in a drip *pdq* (pretty damn quick!) and just the act of puncturing her skin sent her into a full-scale Addisonian collapse. Thank goodness for the hydrocortisone I had drawn up, but it was a fraught half-hour.The Senior Registrar at Farnborough was James Moir-Shepherd and how lucky I was to get such a painstaking teacher. It would be hard to give you a thumb-nail sketch of James. His appearance alone would have had the 'Recording Angel' taking up shorthand in an attempt to describe the clothes he wore. Immaculate is the first word to spring to mind. Tubby Evans, my boss, had advised me to take no notice of what he looked like but to listen carefully to everything he said—and this I did. Many stories abound about Moir-Shepherd—most of them are now more mythological than factual; like the one about the notice he put in the Nurses' Home after he qualified to the effect that he no longer wished to be known as 'Queer Jim' but as 'Strange James'. All I know is that every Thursday we would settle to 'The Two Ronnies' on BBC1 after a hard day in theatres and he would always pass me a cheroot to smoke and we would enjoy the show together. Little did I know that one day I would meet one of the aforementioned Equity Card Holders. Fate is indeed strange.

One night I admitted a woman with one missed period and some abdominal pain. I clerked her in, and, having made sure she was safely tucked up in bed, I went to bed. Some 15 minutes later the phone rang. It was James,

'You know that patient you've just admitted,' he began, 'You'd better come along and take a look at her.' He always spoke calmly but I'd learnt the importance of jumping to it when he spoke like that. I duly arrived five minutes later and saw a woman of the most ghastly pallor who was lying terribly still. There was no doubt that this was an ectopic pregnancy that had already bled extensively, and I remember running for the two pints of 'O negative' blood whilst he got theatres ready. Such was her blood loss that the operating table had to go up and down like a see-saw during the operation just so the anaesthetist could keep her going, and her survival was a tribute to surgeon and anaesthetist. As for myself, I felt so much smaller, but grateful that James Moir-Shepherd had had the wisdom and foresight to check on my work and save me from the consequences of inaction. I was very sorry to see him go back to Guy's, as everyone was, and I am not exaggerating when I say that many of the nurses and midwives were in tears on the day he left.

Guy Nash was our next Senior Registrar and his reputation for being something of a task master had preceded him once we knew he'd be next man in. His arrival was awaited with considerable trepidation. This was somewhat unfair because all the midwives took to him immediately. It was Obstetric Dressers who tended to get eaten for breakfast and I'm sure we deserved it at the time. On my first night on duty with him I was summoned to the Labour Ward where I found a Chinese woman, gravida eight, fully dilated with a prolapsed cord and foot protruding from the vulva. I told the staff to get hold of Guy Nash *pdq* whilst I scrubbed at lightning speed and then proceeded to do a breech extraction using the Drew-Smellie-Weit manoeuvre as I judged there wasn't enough time for the Wrigley's forceps to the after-coming head. In the event, a large boy with an Apgar score of 1 was born and by the time I had got him going one very out-of breath Senior Registrar had arrived. His car battery had been flat, there was a white frost on the ground, and he'd run all the way from the SR's accomodation in Fanborough Park. After that bit of excitement, we all got along rather well together but I'll never forget it as one of the more harrowing moments in my obststric career.

The Neonatal Unit at Fanborough did very well with premature babies—and remember this was 1971. One night I was allowed to deliver a set of twins at 28 weeks gestation. The mother I had seen in Outpatients that morning, and I could only feel the one infant and there was no instant scanning facility available. Patients had to go to Guy's for such facilities. I remember the mother in question reporting some discomfort but with 50 mothers-to-be to see in an hour and a half, I was unable to do very much except to make reassuring noises. She went into labour very soon afterwards and it was the midwives who thought there were two on board. Their weights at birth were 1lb 13ozs and 2lbs 1oz. Their survival was the greatest possible tribute to the neonatal facility available at the time, and bore out the mother's faith in British medicine. She had known she was losing liquor when boarding the plane in Africa and she had made a dash for home only 24 hours previously. I only got the full story clear in my mind afterwards.

The epidural anaesthetic was only just beginning to come into usage and was used when labour seemed to be going on a bit. Pain relief was done with the 'gas and air' device and a substance called pethilorphan, a mixture of pethidine and levallorphan. Pethidine was widely used in that it helped the pain in the mother but it had been noted that it reduced what used to be known as the 'respiratory minute volume' in the baby. Levallorphan 1.25mg per 100mg pethidine, was thought to help this situation without reducing analgesia. Where morphine had been given then nalorphine would be administered to the mother before the birth of the baby on the same grounds.

Practical pranks—then and now

I remember when I was a student at Farnborough in 1968 the SHO was Chris Newman (now Dr C L Newman FRCP, Consultant Paediatrician, Royal Berkshire Hospital, Reading). He was extremely popular with the midwives and the price of that popularity was that he got set up in much the same way that that TV entertainer, Noel Edmonds, gives unsuspecting members of the thespian brigade a hard time in inappropriate settings.

We set up an eclamptic fit in labour during a quiet spell when there was nothing much going on. Distilled water was drawn into syringes so that there'd be no hard drugs bandied about and the midwife, a Chinese girl with a penchant for mimicking the situation, put a smock on and did whatever it was that had to be done to make herself look suitably awful. It was a brilliant wheeze, and rather frightening to me, the onlooker, in that so convincing was the performance, the lighting—it was night—and the general air of panic that poor old Chris actually mainlined the patient with the distilled water before the ruse was discovered. I think he took it awfully well, but I'm sure he's never forgotten it.

Since my son passed out of the Metropolitan Police Training School at Hendon, these practical jokes have come back to me. Cling-filming the ladies toilets is still a very popular ruse with somewhat distressing results. One stretches the cling-film across the porcelain—it takes two miscreants to achieve the right result—and then one lowers both seats so that all appears to be normal! One of my son's colleagues pasted black boot polish round the insides of his friend's helmet, just before they were due to go on parade. I'm pleased to report that the 'friend' managed to say, 'What's all this then?' just in time and taped the inside of the headgear with masking tape thus saving the day, but depriving the mischievous element of a good laugh. At time of writing I am very pleased to report that the family policeman's career is going along alright and he has just arrested someone for stealing a cheese sandwich. Apparently, the felon has already stolen six cheese sandwiches.

The most impressive delivery I ever saw was by a primigravidid lady who had been a serious practitioner of yoga. I appeared at her side in the Labour Ward and offered the usual advice and was promptly told to be quiet. She was very nearly fully dilated and her breathing was a masterpiece of self-control. I offered her an episiotomy and was told to go and micturate elsewhere but in spite of her spirit I was allowed to stay with her as she achieved what amounted to the perfect delivery. I mention this story because we live in the days of the high technology delivery. One evening I visited a friend in labour with her third child. She was due for an elective Caesarian Section anyway, but had managed to jump the gun. She was attached to a monitor and there

was a length of paper spewing out of the side of the machine. The SHO of the day came in and, without so much as a word to either of us, looked at the piece of paper. Then he left as abruptly as he had arrived and we looked at each other. I shared my sudden need to examine the radiator under the window with my friend—and she laughed. My main gripe with the current attitude is the potential for depersonalisation of the gravid woman in labour when she is wired up to monitors and drips which beep from time to time.

The nicer things in life

I wrote to my Bank Manager to protest over the appalling level of bank charges conferred upon us 'small businesses'. I said that when I was a lad the Chief Cashier used to give me a boiled sweet whenever I went to pay in the family earnings. I mourned the passing of that boiled sweet and all it stood for—the Chief Cashier and people like him. I actually received a barley sugar from a patient the other day—on the doorstep it was, just as she was taking her leave of me. I was so moved that I have the said sweet on my bedside table, as a mark of a by-gone age when it was the little gestures that made all the difference. In Obstetrics, it is all the rage to make a series of really grand gestures. There are scans, blood tests for all sorts of things, unsolicited visits from health professionals, amniocentesis—either quite late in the first trimester of later on in the time-honoured manner. There is all manner of advice too, and it can be forgotten that having a baby is a normal physiological event which I feel is gently being turned into a high-technology illness. I know that we are all keen to reduce the peri-natal mortality, but for us in the British Isles it's rather an uphill struggle and I just wonder whether it is a chill wind that blows down the Labour wards up and down the country these days. A kind word, a sense of humour, a friendly face—all these help more than any medical scientist will ever know because they are emotions and, as such, are unmeasurable in scientific terms. I find a new word has crept into medical jargon viz management protocols. There are other phrases which haven't got in yet—but they are well under way, 'due diligence', 'niche marketing'. One of my patients—a student in Birmingham—was faced by a doctor with whom she felt she had to fight for the diagnosis I had imposed on her. She was asked about her GP and was told that I was 'provincial and out-of-touch'! I was quite delighted about this but the doctor in question did not win the day for himself. We live in a world which is not going to respond to a lot of the intellectual solutions we impose on it—or each other. Remember the boiled sweets; it's the little things that mean a lot and it is those things alone which tend to mediate between triumph and disaster.

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Anaesthetics

The Obstructed Airway—Video. SSVC, Price £59.95. Orders or enquiries contact Aline Simpson on (02407) 71737/8.

This is a 32 minute video (with instructional booklet) covering all aspects of airway management and ventilation. Produced by Surgeon Commander Tighe of the Royal Navy (a Guy's graduate) it is useful for anyone learning to manage airways of unconscious patient.

Starting with the recognition of the non-breathing, unconscious patient the video moves rapidly onto the identification (very well done) and the management of the obstructed airway. Manual methods of airway support are shown, using a mixture of excellent graphics, animation and genuinely unconscious patients. The correct use of artificial airways and intubation are demonstrated and the hazards of failure to intubate discussed. Realistic simulations of foreign body airway obstruction, together with back slap and abdominal thrust manoeuvres are included, as is Cricothyroidotomy. Finally different techniques for ventilating the patient who has a clear airway but is not breathing are discussed. The basic message of the video is that simple techniques are adequate for 90% of obstructed airway cases.

Overall this is an excellent video. We can recommend it as part of any practical course in airway management. And, as frequent retraining in skills is important, this video might be very useful in hosptital libraries to reinforce practical training.

U M Hodges
Lecturer in Anaesthetics
W de Mello
Senior Registrar in Anaesthetics

Anatomy

Textbook of Anatomy.A W Rogers. Published by Churchill Livingstone. Price £29.95.

This voluminous text considers anatomy by a systematic approach. No assumptions are made concerning previous knowledge; the first section is a basic introduction to anatomy. The study of anatomy, growth and ageing are covered and a brief overview of each systemgiven, starting with the skeletal, and working through to the lymphatic system.

Thereafter each system is dealt with individually in greater detail. At the beginning of each section there is a short review of previous chapters detailing assumed anatomical knowledge. Throughout each section there are boxed areas giving information such as common problems and clinical testing. The section ends with a few clinical problems (answers at the back). Also at the back is a full glossary of Nomina Anatomica terms and an index and regional contents guide.

The new BMS curriculum follows a systematic approach; this text certainly has a place in it. Yet, it is somewhat unsatisfactory to have to flick from one system to another in an attempt to build up a picture of, for example, the hand. The text makes little attempt to place the independent systems into a realistic view. Whilst an appreciation of the various systems within the body is vital, anatomy is not conducive to anything other than a regional approach, after all is that not the way that the patient generally presents?

This text certainly has a place as a library reference tome but its purchase is not advised for each student.

D S M MacLaughlin
Division of Anatomy and Cell Biology

Sheila Kumarappan

On 27 January 1993, Sheila Kumarappan died tragically following an asthma attack from which she did not regain consciousness. She leaves behind her husband, Alex, parents, a younger brother and many relatives and friends who will miss her deeply.

Sheila came to Guy's in October 1987. Prior to this, she was at Chislehurst and Sidcup Grammar School, where she was an outstanding pupil, popular with students and teachers alike. She continued to be successful academically at Guy's. Her limitless energy and cheerful disposition ensured that she had an enjoyable start to her time at Guy's, having made many friends.

Sheila decided to intercalate a BSc in immunology after her pre-clinical years. Though this involved much hard work, she had an unforgettable and thoroughly enjoyable year and built up some lasting friendships with her colleagues. It was in the same year that she married Alex, who soon became a friend to many at Guy's.

As a clinical student, Sheila was very quick to learn, and with her intelligence and enthusiasm a bright future as a doctor was promised. Sheila will always be remembered as an individual with great determination and strength of character; someone who was always smiling and to whom laughter came so easily. She was also a great friend, supportive and always willing to listen and offer advice.

Our thoughts and sympathies are with her dear husband and family, whose grief cannot be expressed in words. Her death is a loss to us all, and she will be remembered by those who knew her with much affection.

D Davies and K Sharma

I don't believe it

I had intended to commence this little essay where I left off last month. Unfortunately at the time I write, last month's *Gazette* has not yet appeared, so this month's, which is still next month as I write, will have to start from what I recall of what I wrote. Some of you may wonder, don't I have a copy of what I wrote? Well, yes I do, but if you saw the state of my desk and the piles of paper all over it, some frequently falling onto the floor, you would not be surprised at my inability to find it. Anyway, thank your lucky stars, at least you are not married to me—what my poor wife thinks of this mess...

I think I was bemoaning the state young nurses find themselves in, the prospect, or lack of it, for their future in the nursing profession, and the general gloom that pervades. Less nurses and more managers was part of the theme, I seem to remember. And what of the 'vision' our managers try to purvey in their missives about the merger between Guy's and St Thomas's? The word 'vision' seemingly littered their memo; maybe they overdosed on Tennyson's *Locksley Hall*, which, 'saw the vision of the world and all the wonder that would be'. Anyway let's hope it's brighter than the present. If, like Mr Major, I 'wunt' any visions I try the excellent cider, up from the west, which they now have in the Wheatsheaf, hard by Boro' Market. Oh yes, and then I mentioned Professor Besser last month—name dropping someone called it. What nonsense, I had not thought of his name in years and had only just picked it up.

All this leads to an examination of stress in nursing. I recently came upon a bunch of nurses scowling ; difficulties in the profession, poor pay, bullying doctors and horrid patients—you know the sort of thing which keeps us all happily grumbling at times. But the specific of their moan, and from which they deduced the stress of the job, was the unreality of it all.

Being nice and kind to patients, relatives and other staff, when they would like to speak their mind, is tough and stressful to some nurses. They have heard about the good old days, before hospitals put themselves in the market-place; when sisters struck terror into student nurses and patients—the patients were told what to do rather than the other way round, as it seems to them today. Certainly there is a grain of truth in this; nurses were often nasty to patients and thought it was within their rights so to be. I was smacked by a nurse, when far too young to either enjoy it, or know that some folk paid for the privilege!

In those days it was a privilege rather than a right to be cared for. Today, we are encumbered by what I call 'oleaginous expletives', such as, 'have a nice day', 'take care' and 'there you go', all of which I 'take on bored', and along with other nurses parrot these ugly phrases to those whom we serve. It all means an element of hypocrisy enters into each patient-nurse transaction. I, as founder of 'hypocrites anonymous', don't mind so much, but I hear nurses complain that they feel as if they are acting a part. I therefore ask, have they not heard of the role of the nurse? Do they really suppose that whoever plays the part of Lady Macbeth is so horrible once she leaves the stage?

That excellent television series *One Foot in the Grave* shows all this very well. Victor Meldrew snorts, 'I don't believe it'

at all life's irritations, and his long suffering wife bites her lip as she has done for the past 35 years. What a strain, what stress she endures. I often wonder if my own wife sees herself cast in a similar role, but I dare not ask.

Yes, nurses do suffer stress, but really, learning to be a nurse, and especially putting on the uniform, is part of the skill of taking on the role. Finding it all too much is surely a sign of having chosen the wrong profession, or at the very least, not having trained properly. If we don't like the heat we must get out of the kitchen, and if we don't like acting up to patients' whims and fancies, try elsewhere. I hear some nurses have left the bedside to become managers.

Denis Cobell

Copy for the *Gazette*

Articles for inclusion in the *Gazette* should be supplied double spaced, and preferably word-processed or typed. If handwritten, names in particular should be written legibly. If contributions are prepared on a word-processor, it would be particularly helpful if a floppy disk containing the article is supplied along with a printed copy. Where possible, text should be saved in ASCII format—or if in any doubt, full details about compatibility of different files can be obtained from the *Gazette* office.

All feature articles should be approximately 1,500 to 2,500 words in length. Late news and sports reports can usually be accepted three weeks before publication. Authors are requested to supply a contact phone number in case of any queries that arise. The *Gazette* would also particularly welcome results of any original research carried out in the course of BSc or other project work.

So, now you know what to do to get your name in print—get writing! Final year students are requested to send in material about their electives—even if it only consists of anecdotes.

A tribute to Diana Innocenti

It was both happy and sad to be at Diana Innocenti's retirement party on March 24. It was universally sad, however, to read her last 'Physiotherapy Notes' and to learn that there is no apparent successor. I do most strongly agree with the observation in Passim that 'it would be a great shame to lose this aspect of the *Gazette's* coverage.'

However, it would be as great a shame if more note were not made of Diana's contribution to Guy's and to physiotherapy in general, because many of us worked alongside her during her 25 years without making anything like the impact that she made. Fortified spiritually by a faith which she was able to translate into practical terms for the benefit of both patients and colleagues, she made a positive input into the lives of the staff and students of the Physiotherapy School, which was unmatched in my experience. There must by so many young, and not so young, physiotherapists who would gladly acknowledge their debt. I stress 'positive'—it is easy to find fault with and to demonstrate the shortcomings of others; much less easy is it to pick out their virtues and to foster them. Counselling is not a new concept, and Diana was adept at helping others, patients and staff, to realise and to build on their strengths.

I was party to many interviews with her for senior physiotherapy staff, and was repeatedly made conscious of her objectivity, softened as it was by a compassion which usually approximated itself to my perhaps more subjective judgements. On other occasions, she joined me in examining many of our finalist students, and again I was struck by her perspicacity.

She was an excellent speaker, at whatever level, and as readers of the *Gazette* will know, she also handled the written word with assuredness. Probably no physiotherapy student in recent years will be unfamiliar with her chapters in the standard physiotherapy textbooks edited by Joan Cash.

But above all, she was a practising physiotherapist of the highest quality, and her friends and colleagues at Guy's, while remembering her with great affection, must be sorry that she had to go.

Ronald Cooper

"Quote-Unquote"

Sir William Osler in *Aphorisms from his Bedside Teachings* (1961):

'Failure to examine the throat is a glaring sin of omission, especially in children. One finger in the throat and one in the rectum makes a good diagnostician.'

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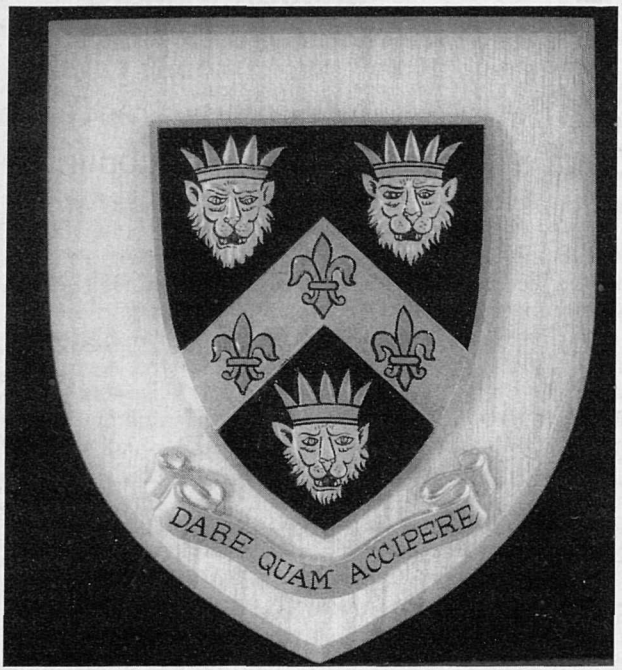

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UL Head of the River December 1992

This was a new event in the University rowing calendar held a week after the UH Regatta, reported in the February *Gazette*. Intended as an end of term time-trial for anyone interested, the race was free to enter, but offered no prizes. After the success of the previous weeks, it was at first glance unlikely to wet the appetite of the now trophy-hungry Guy's crews, particularly since it coincided with the week of the pre-clinical end of term exams. Nevertheless, a row of some four miles from the Pink Lodge to Barnes Bridge was ultimately a challenge that the hitherto all-conquering men's novice squad could not resist. Therefore it was no surprise that a scratch composite crew drawn from the men's novice A and B crews rowed superbly in their first head to be fastest novice crew home. Being the first opportunity for the squad to be compared against all-comers, everyone was delighted when the crew also prevailed over a number of college second VIIIs despite the latter crews' vastly superior experience. With the proper head season only a couple of months away, the other colleges had been warned.

With the 1st VIII shell *Michael Gleeson* being used by the novices, the men's 1st VIII squad entered a scratch coxed four (Neil Harrison, Martin Whitehead, Alex Cash, Spencer Hodges, and cox, Emma Helm) 'just for fun'. Despite rowing in a 16 stone(!) bow-side stroked boat borrowed from Tideway Scullers that morning, the crew had a relaxed row coming off the water quietly confident. Confidence turned to disbelief when the results were announced awarding the crew a time a minute slower than that clocked by the cox. Closer inspection of the figures revealed however that a Queen Mary & Westfield novice VIII which had been overtaken and which was some nine lengths behind the four at the finish line had apparently crossed the line 32 seconds before it! A quick chat to UL rectified the error to make the crew the fastest four in the race and give Guy's its 20th win of the season.

Jonathan Robin
Captain

Christmas Pudding Races

In true tradition GHBC ended the winter term with the Christmas Pudding races. This year a fog-free day permitted the crews to race over a 200m course on the Thames at Chiswick. Over 80 people associated with UMDS participated in the event. The majority were club members but netball, rugby, football and hockey players, as well as staff and family members joined in the fun.

Crews were selected randomly, GB rowers enthusiastically mixed in with non-rowers and Australian girls. After several gruelling rounds 'Nessy's Nymphs' beat 'Rob's Rollocks' by a 'canvas', despite what 'Hob-Nob' thinks. Winners, including Mr Michael Gleeson (Boat Club president), were presented with elaborately engraved tankards by Spencer Hodges, the compere and tarzanogram. Competitors were warmed throughout the day with copious amounts of mulled wine, lager, potatoes

and chilli, not to mention the fabulous Christmas pudding.

The day had just begun and yet house surgeons were soon stripping, respected technicians kissing and as for the Australian girls—pass the parcel has never been so good. Captains past and present disgraced themselves in the frenzied 'tangle of the string game', as the string went up the skirts and down the trousers.

No account of this day would be complete without a mention of the efforts, precision-planning and culinary creations of Ruth O'Sullivan, our tremendous social secretary.

Louise Ward
Ladies' Captain GHBC

Peterborough Head of the River

Early February saw the men's and ladies' 1st VIIIs entered in the Peterborough Head. Hampered by a late departure from Chiswick, delays on the A1, absent sign-posting and reckless map-reading, the crews only began to arrive just as the last of the opposition were paddling to the start. With the men's boat on the pontoons, the last minute press-ganging of chief supporter Dr John Crossman was only narrowly avoided by the sight of Spencer Hodges tearing towards the landing stage wearing his usual manic grin. No one was more relieved at this late appearance than the aforementioned Dr Crossman who (despite six months as a House Physician at Guy's) was just getting used to the idea of some *really* hard work for the first time since finals. With less than 20 minutes to go before the start, the crew belted up the course which to eyes accustomed to the variety of the Tideway, appeared to have been designed by some over-enthusiastic irrigation engineer.

When the race finally came, it could only be described as 'good in parts' for both crews, each finishing around midway in their respective Senior 3 divisions. In retrospect, perhaps it was not too bad for the first head of the season rowing in an unfamiliar, landmark free, wind swept ditch and, of course, valuable lessons had been learned. However, perhaps the most constructive part of the whole day was an impromptu meeting on the steps of the nearby playhouse to determine the club's response to the latest threats from the student union on the merger issue—it was perhaps highly appropriate in the circumstances that the playhouse was currently hosting a puppet show!

Finally, we must thank Dickie Simons for all his efforts towing the boats to and from the event.

United Hospitals' Head Race

Ten days after Peterborough, Guy's organised the UH Head Race for VIIIs which this year had a large entry of nearly 40 crews. In order to enable doubling up of equipment, the event was held in two divisions with the course running from the Pink Lodge to Chiswick Bridge.

With some senior members taking time out to organise the event, a scratch men's 1st VIII stroked by Alex Cash powered down the course in the long, strong and relatively slow rhythm for which he is renowned to finish third overall narrowly behind the London and UCM and

winning their Men's Junior division easily by 56 seconds. Of particular note in the crew was Sid Nene who joined from the 2nd VIII and made an impressive contribution to stroke side in the No 4 seat.

The ladies' 1st VIII (Sharon Payne, Amanda Bowman, Louise Ward, Michelle Roberts, Emma Parkinson, Kate Prior, Chrissy Carey, Julia Thomas, aka Poppet, and cox, Mo Roy) fresh from a selection trial the Saturday before, also rowed superbly to win its class convincingly.

An hour or so later in the second division, the ladies' novice A crew (Clare Emery, Loraine Fisher, Jane Neerkin, Hannah Lord, Monica Dandekar, Jane Who, Nina Barrows, Nicola Ballard, and cox, Rob Huggett) set out to prove yet again they were the best novices in the University. Witnessed by the writer, the ladies rowed with a degree of style and determination that very much belied the fact they had only taken up the sport four months previously. No one was therefore surprised when they won the Women's Novice division easily by 42 seconds, beating four Women's Junior crews in the process. Most spectacular however was a race time 21 seconds in front of the St Thomas's ladies' 1st VIII.

With an unbeaten record so far, the men's novice squad entered two crews which once again had spent the preceding weeks practising side-by-side in some exceptionally arduous training. This had deliberately included weekly continuous pieces from the Pink Lodge to Barnes Bridge so that, by the day of the race, the shorter UH course would seem less daunting. Both crews had been well matched in training and the stage was set for an interesting race with the two crews heading up their division. Despite an equipment problem on the start which almost caused a log jam, the novice B VIII attacked the course with all they had. The novice A VIII had a better start but only managed to catch the B crew by the UL boathouse, both crews pushing each other for the remaining few hundred yards to the finish. When the results were calculated, the success that had been heralded by the head race before Christmas was well and truly confirmed with the A crew coming fifth overall(!) to win easily the Men's Novice class, their only serious novice rivals, University College & Middlesex, once again resigned to second place. Fifth place was also good enough to prevail over several first crews and all the second crews competing. The B crew having done its job of pace making so well finished a very creditable eleventh overall, coming third in the Novice class.

Guy's now had twenty-four wins.

Thanks must once again go to all those non-rowing volunteers who gave their time to officiate on the day—Michael Rocker, Annabel, Andy Klein, Sara-Jane Leigh, Sona Biswas and Charlie Sherwin.

UL Head—February 1993

One week later Guy's entered the traditional UL Head. With only one division and with the men's novice squad going for the 'grand slam', the men's first crew ceded their boat and blades to them. Enter yet again another scratch coxed four (Alex Cash, Neil Harrison, Jonathan Robin, Spencer Hodges, and cox, Emma Helm). Despite being pushed fairly hard by UCL for most of the course, which this

time ran between the Pink Lodge and Barnes Bridge, superior steering and a burn at the finish ensured victory in the Open Fours class.

With the ladies' 1st VIII deciding to concentrate on preparation for the Ladies' Head of the River Race, the ladies' Novice A crew were also able to use the best equipment the club had to offer. Highly motivated after the success of the week before, the crew stormed down the course to win the Women's Novice class easily, once again prevailing over many second crews.

So far as the men's novices were concerned, the writer was just a little apprehensive that some thing would go wrong to deprive the squad of its ultimate achievement, particularly since two injuries and a crew member called away the night before due to family sickness forced a last minute rethink of the line-up. Instead of two VIIIs, a composite VIII and IV were entered. At the end of the day any fears were unjustified, the VIII (with a new stroke) powered down the course to become the fourth fastest college crew overall, once again easily winning the Men's Novice class and once again prevailing over a number of first crews and every second crew entered!

This performance was the crowning glory of an exceptional season for the men's novice squad, all of whom, let it be remembered, only began rowing in October. Crews drawn from the squad have won every men's novice title in inter-collegiate and inter-hospital competition this season. If that were not enough, to be placed fourth and fifth overall in the UL and UH Heads respectively, must rank as one of the finest performances of a novice crew ever. The squad members are as follows: 'A crew': James Mackintyre, Dillon Jewell, Nick Marshall, Craig Knighton, Ed Nash, Finbar O'Sullivan, Carl Stevenson, John Anns and cox, Christie Goldsmith. 'B crew': Steve Lewis, Kevin Boid, Enis Guriel, Alex Jeans, Daniel Hornan, Mathew Lovel, Barry Millar, Oliver Minton and cox, Lucy Wigmore.

City of Bristol Head of the River

Nobody quite knows why the 1st VIII went to Bristol the week after the UL Head, but ever since the Secretary vaguely waved the promotional material in the crew's direction, the event had been eagerly awaited. After a Saturday morning training outing on the Tideway which was already filling with crews practising for the Women's Head that afternoon, the bulk of the crew departed to stay the night at Alex Cash's house in Oxford. Many thanks to his parents for providing such warm hospitality.

What precisely happened on Saturday night to cause the club's devoutly Catholic Vice-Captain to be found stark naked in a graveyard at midnight will probably forever remain a mystery, but it provided the source of much conversation on the way to Bristol early on Sunday morning. Although the dramatic entry of our specially hired K-registration Range Rover in the boat park caused a few raised eyebrows, it was not until Alex Bodie and Dickie Doyle ram-raided a line of traffic cones on their arrival that the peace was well and truly shattered.

One hour to go before the race found Guy's sitting on the pontoon waiting to depart, closely watched by the Royal Military College of Science. The latter

could scarcely stifle a barrack-room snigger as Cox confidently commanded, 'Ready, Square blades, Go!' (At this point it should be explained that RMCS had narrowly beaten a Guy's IV into second place in the first event of the season and they clearly fancied their chances this time.) The sniggers however abruptly halted as the exercise was effected faultlessly, the boat passing majestically into the River Avon and onto the end of the sinuous 3500 meter course, running through the docks into the city centre. Whilst paddling to the start, Cox began to look more worried than usual since the first half of the course contained four narrow low bridges, lying on a series of sharp reverse curves. Some exceptional steering would obviously be required.

Paddling onto the start, RMCS were by now looking distinctly worried. Within a minute we were off and immediately entered a long tunnel under Temple Meads station, the sound of the finishes at an even thirty-two resonating off the damp walls. Out into the sunlight and we were already closing on the crew in front. Meanwhile, RMCS had now started off behind and seemed to match us for speed. After the first bridge, the boat in front was swiftly overtaken and the crew settled into a long powerful rhythm which saw RMCS slipping into the distance. Three more bridges and the boat was still moving almost effortlessly despite rougher water. Suddenly, the *SS Great Britain* came into view which was the cue for the rate to increase as the boat sped toward the finish now only a few hundred metres away. As we crossed the line, we were pleased with our performance and—not for the first time this season—quietly confident. And, indeed, an hour later the results showed the crew had won its division leaving RMCS some thirty-five seconds behind. As we returned to watch the second division row, no one could believe how skilfully we had been steered through those bridges at full pressure. It was a mark of our cox's talent that, despite only picking up rudder strings for the first time in October, she steered so well on such a difficult course. The 28th win of Guy's this season must be dedicated to her. The crew was: Jonathan Robin, Neil Harrison, Alex Cash, Spencer Hodges, John-Paul Carpenter, Martin Whitehead, Dr. John Crossman (replacing Marcus Newbold in exam week), Andrew Hobkirk, and cox, Emma Helm.

The less said about the journey back the better suffice to say that it involved an impromptu 'visit' to the Bristol Dental School. Any rumours of the convoy, boat trailer and all, flashing at high speed through the A & E department of Bristol Royal Infirmary are greatly exaggerated.

Jonathan Robin
Captain

Rugby: 1st XV

Guy's 1st XV v Winchester. 9 January. Won 22-12.

This was an extremely important game for Guy's chances in the Courage League. Having lost in an appalling game in Jersey in December, the pressure was beginning to rise.

From the kick-off Guy's were in trouble. Pinned on their line, a misjudged lineout throw was cleared up by Winchester and the visitors were 7-0 up with a minute gone of the game.

It took about 15 minutes to warm-up but the end result was worth it. Guy's began to dominate and to play some in-

telligent and, dare I say it, 'percentage rugby'. The pack began to take the initiative and the backs played a very fluent and enterprising game, whilst maintaining a solid line of defence.

The first try was a well-conceived move from a solid scrum. A dummy to the inside centre put Baker into space and he used it to its maximum, leaving a trail of prone tacklers from the ten-yard line to the try line. The conversion, plus a later penalty from Llewellyn, gave Guy's the lead which they never after lost.

The second half saw two more tries for the backs. Again Baker came onto the ball at pace, made twenty yards before passing inside to Alan Jones for the try under the post. Winchester did reply with a consolation try through a Guy's mistake. Breeze had the final say with a lucky bounce and some very fast moving.

A solid performance all round. A 'B-plus' performance, though still room for improvement.

Guy's v Westcombe Park. 16 January. Lost 14-19.

This was the first ever encounter between Guy's and Westcombe Park and it was not an easy game. The pitch was heavy underfoot, a howling wind blew steadily down the pitch, restricting the full 80 minutes to one half of the pitch and the opposition pack were *big*. The first half saw Guy's trying to play a containment game, which was not helped by three tries being allowed in from 50 feet and enforced errors, giving Westcombe Park a 19-0 advantage at the changeover.

The second half put the wind into Guy's favour, and they certainly used it. Despite an unfair advantage in the line-outs, (they were taller and could catch), Guy's competed well at scrums and second phase balls and produced two well-constructed tries for Steve Lewis, (welcome home Steve).

With the score at 19-14 Guy's applied the pressure but unfortunately time was unkind, and a likely scoring position five yards from Westcombe Park's line was cut short by the final whistle.

The Westcombe Park side had not played well, according to their supporters. Fair play! We didn't let them.

Guy's Hospital v Old Walcountians. 17 January. Lost 26-42.

The following day was the 2nd round of the Surrey Cup against Old Walcountians, whom Guy's had beaten in the league 45-12. Things were different this time. For a start Guy's had 14 players' injuries. They arrived late and, true to all Sunday games, did not want to play. However when Old Walcountians scored a try in the first 10 seconds and proceeded at that pace for the first half, Guy's decided to start to play. The result was a much more entertaining style of play albeit aided and abetted by a fairly liberal referee. Tries from Neil Davies, Pat Gush (2), John Murphy, and a few others I cannot remember highlighted the fact that if we had had 15 players (in their proper positions) and a will to proceed further in the competition, things might have been different. Maybe next year...

Guy's 1st XV v Old Becckhamians. 23 January. Won 8-7.

This was a tester for Guy's, OB's, in an equivalent London League, were 2nd in their group. The weather, the pitch and the firsts did not help the cause.

Following John Webb's efforts for England against France, the high ball became just as impossible for the Guy's defence, 7-0 OB's. A real struggle then began with the Guy's pack having the better of their opponents, but a reversal of fortunes was occuring for the Guy's backs. A sort of stalemate developed, and the game became a 'kick-it-and-see' battle.

With ten minutes to go, Guy's produced some usable balls from 2nd and 3rd phase possession, and, with good support from the forwards, Ed Barrio scored a well-deserved try. He claimed he was going for the posts but tripped over a stone, 7-5 to OB's. Neil Davies then floated the most beautiful drop goal I have ever seen. Well, in fact, it looked like a pregnant guinea fowl with flatulence trying to land in a hurricane, but three points is three points.

Guy's v Purley. 13 February. Drew 15-15. The weather was very pleasant and the ground soft but still good for rugby. However, both sides played with a heavy dose of lethargy in the first 10 minutes. Purley dominated the line-out throughout, (what a surprise), and from this they took an early 7-0 lead, after breaking the sluggish Guy's defence. Almost immediately, Guy's replied through a surprise choice at wing-forward of Salman Rushdie. He charged down an attempted clearance and avoided a knock-in to score.

Coming into the last 20 minutes of the first half, Guy's began to take control and Rushdie suddenly popped up from nowhere on a free-kick move and, foiling the defence, scored his second try.

The second half started with continued Guy's pressure and Docker scored a typical 'Docker' try to put Guy's up at 15-7. From here to the end Guy's seemed to be penalised for playing! Purley were able to mount continued pressure, from which they scored only one penalty (from countless awarded to them) and a try (must have been forward ref!). The score, 15-15. Guy's could have sealed it in the last minute, but an eagerness to get things done was spotted by the referee, and the ball was kicked dead. Game over and the question in the bar was of a point saved or a point lost. The referee told us we should have won. No kidding!

Guy's saute XV v Askeans II. Won 62-10 On March 6 1993, Guys played away to Askeans's 2nd team. The Guy's team was as near to normal as possible, apart from Richard Dales who had been drafted in from McDonald's earlier that morning, to replace the ill Graeme Lawton.

A hard game was expected from Askeans, their first side being in National Division 3. However Askeans were in trouble from the start, due to aggressive scrummaging by the Guys pack. Within a few minutes, thanks to a solid front row, Bates and Dales in the 2nd row drove the Guy's scrum over the Askean try line, allowing Beardmore at no 8 to go over for the pushover try. Despite a try from an intercepted pan and one penalty, Askeans struggled throughout the game against dogged forward domination and clever movement of the ball by the backs. Ten tries were scored in total

Team(tries): James Burt, Ben Stanhope (capt), Alex Haift, Andy Bates, Richard Dales, Andy Styme, Charles Beardmore (5!), Richard Docker (1), Steve Lewis (2), Pat Gush (1), Alex Jones, Guy McClellen (1), Mark Howells.

Men's Football Club

Guy's v UCH 2nd XI. UH Junior Cup Final. Won 3-2.

On Sunday 28 February UMDS 3rd XI, nicknamed the 'Cobham Tigers', entered the annals of UMDS sporting history by bringing home the UH Junior Cup. Anyone present at the final at Motspur Park will surely admit they witnessed a sporting spectacle, as gripping as the most exciting FA Cup final, as tense as any World Cup shoot out.

The first half produced scrappy performances from both sides, with few chances at either end. As the second half progressed it seemed that if either team scored that would be enough to separate the sides. Then disaster struck. A long ball from the UCH midfield was converted by the knee of a UCH stricker, to leave the Tigers 1-0 down.

Then it started snowing. The Tigers were 1-0 down, playing uphill into a blizzard, with only 10 minutes left. It seemed as if their Cup luck had run out. Indeed, momemts later it would have all over if skipper Amijid Khan had not cleared a certain goal off the line. However UMDS support didn't fail. Lead by team entertainer Elliot Smith they outsang the larger UCH support with a roar that could be heard as far away as Cobham.

As Rutesh Mehta once said, 'a tiger is never more dangerous than when it is cornered' and indeed, with five minutes remaining, the team gave the crowd what they wanted. Cobham's no 1, Bharat Gadhvi, came off his line to make a clearance and spotted Chris Rawlingson making a forward run. An inch perfect pass ended with the ball at Chris' feet and, with just the keeper to beat, he smacked the ball home into the roof of the net. The fact that Chris plays centre-back and is our leading scorer speakes volumes for the talent of the man.

Minutes later the battle could have been won. Unfortuantely a further shot from Chris was cleared off the line and even two late bursts of excitement from Nick Kenney, showing his pace down the right wing, could not prevent the match going into extra time.

Tired legs brought more excitement to the situation, the Tigers being able to capitalise on their supreme fitness. No one was quite sure is Simon 'Chunder' Chowdhury was playing in defence, attack. He seemed to be everywhere at once, linking down the left with midfield wizard Zahid Hussain and down the right with Andy Russell, who did not seem to tire despite a fag-induced COAD. In the second half of extra time Simon Williams, the Welshman with the gorgeous 'tash, found the ball at his feet, just outside the box. Looking up, and seeing the keeper out of position, he thundered the ball into the back of the net. This caused a pitch invasion by UMDS supporters, led by team Gynaechologist Anthony Kenney.

Celebrations were short-lived, however. With only seconds remaining UCH were awarded a penalty, which they duly converted to equalise 2-2. Everyone thought that we were heading for a penalty shoot out, everyone but one man, Dai Evans. He weaved his way into the penalty area and punted the ball past the keeper to score a winner. The remaining seconds seemed to last for years, and if Bharat had not made a point blank save in the last few moments, it may well have been a different story.

But then we all really knew that the 3rds would win anyway. The Tigers are

not a team of individuals, they are an individual team, fuelled by guts, determination and team spirit. It is this spirit which nurtured the playing qualities of Rahul Mehrotra, a fresher who produced an outstanding performance, the dedication of Neil Guha, who played with a serious knee injury because he wanted to be a true part of the team and always gave Melvin Vaz those extra few inches to endlessly outjump the opposition in the air. Working together the Tigers showed that team work will always overcome individual glory. A true victory.

Nick Kenney

Mens football team. Bharat Gadhvi, Amjid Khan (Capt), Simon Chowdhury, Chris Rawlingson, Rahal Mehrotha, Zahid Hussain, Elliot Smith, Andy Russell, Melvin Vaz, Nick Kenney, Neil Guha, Dai Evans, Simon Williams.

Summer Ball

on 3 July at

Cobham sports ground

Tickets available from early May. Please help the organisers make this a successful event by buying your ticket early. Discount rates being offered for group bookings.

Blues Awards

Basketball
Half Blues
J Shaffer
M Vaz
W Kutessa
P J Parjam Zolsaghari

Boat Club

Half Blues	*Full Blues*
Louise Ward	A Cash
S Hodges	J Robin
R Simon	
J-P Carpenter	
N Harrison	
Danielle Power	
Ruth O'Sullivan	
A Hobkirk	

Cricket Club

Half Blues	*Full Blues*
E Piper	M Goodwin
R Mehta	
G Buchanan	
R Webb	

Football

Half Blues	*Full Blues*
D Gillett	H Taylor
B Jowett	
J Hollinghead	
J Thompson	
P Kalra	

Ladies' Hockey

Half Blues	*Full Blues*
Juilet Mathhews	Penny Grace
Hannah Reece-Jones	Louise Selby
	Rebecca Williams

Men's Hockey

Half Blues	*Full Blues*
C Heywood	G Harris
T Campbell-Smith	S Moodie

Martial Arts
Half Blues
Sabrina Tsao
E Black

Netball

Half Blues	*Full Blues*
Nicola Macdonald	Alison Currie
Julia Jefferson	
Kate Scanlan	

Rifle Club

Half Blues	*Full Blues*
C Davies	Kier Lewis

Rugby Club

Half Blues	*Full Blues*
J Spencer	B Stanhope
G Tsolkiades	R Breeze
E Barrio	J Combes
E Hughes	G Ryan
J Thallon	R Cunnington
S Russell	M Rose
A Skyrme	J Worth
S Lewis	W Llewellyn

Squash Club

Half Blues	*Full Blues*
P Goodyear	S Walsh
C Nikkah	
G Reddy	

Swimming and Water Polo

Half Blues	*Full Blues*
N Masters	T Srichandra
	P Baker

Ladies's Tennis
Half Blues
Anne-Marie Rees
Caroline Hyzler

Men's Squash Club

UMDS v Charing Cross. Hospitals' Cup match. Won 3-0.

On 9 February 1993 UMDS beat Charing Cross Hospital 4-0 to go through to play St George's Hospital in the next round.

There was a large difference in the standards of the two teams, such that Pete Goodyear, playing at no 1, lost only one point on his way to a 3-0 victory. Ray Sharpe (no 2) and Simon Charlesworth (no 4) both won convincingly, 3-0, while Nigel O'Farrell was the only player to loose a game. He was unable to complete his match as court time ran out. As Glynn Robinson's opponent failed to show, UMDS 'walked over'the opposition 3-0.

Team: P Goodyear(capt),R Sharpe, N O'Farrell, S Charlesworth,

G Robinson

UMDS v St George's. Hospitals' Cup match. Lost 0-5.

On 12 March 1993, after a definitive victory over Charing Cross in the last round, the tables were turned on UMDS, when thay played away against St George's. As George's are an exceptionally strong side this defeat was somewhat expected, the final score 5-0 George's being that usually seen when these two teams meet. This was inspite of everyone playing to the best of their ability. Each player lost 3-0, except Peter Morgan who managed to secure one game in his 3-1 loss.

Despite the score line, I believe the gap between the two teams is narrowing. Who knows, perhaps next year will see UMDS winning the Hospitals' Cup—well, maybe...

Pete Goodyear

Late results . . .

Ladies' football team

The UMDS ladies' footballers stormed through to a 6-0 victory against Bristol in the final of the National Association of Medical Schools competition. The match, played at Cobham, took place on 6 March.

Men's Hockey win

UMDS II v Royal Holloway and Bedford New College

On 7 March 1993 UMDS II won the UL reserve team cup, beating Royal Holloway and Bedford New College 2-0.

Netball

UL Cup final

UMDS 1st v Royal Holloway and Bedford New College

On 20 March 1993 UMDS won the UL cup, beating Royal Holloway and Bedford New College 41 -31.

Birth

POWLSON. To Mark (Guy's 1976-82) and Suzanne, a son, Gareth John, born on 29 January at St George's Hospital, Tooting.

Marriage

The marriage of Dr Anthony J Marino to Dr Elizabeth E Fox on 16 April at St Bede's Church, Weaverham, Cheshire. Both qualified at Guy's in 1990.

Dental practice for sale

Country loving dentist sought to purchase single-handed NHS practice. Large surgery in small Gloucestershire town. Leasehold. Busy book. Happy patients. Independent laboratory adjacent. Evenings phone (0453) 860202.

Classifieds and Announcements

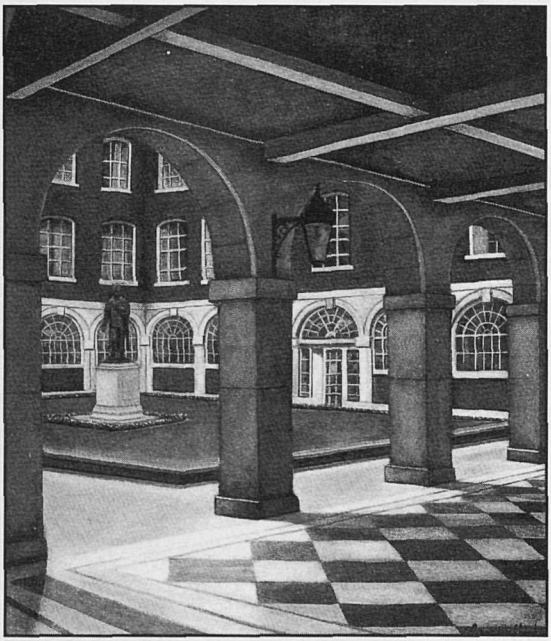
The *Gazette* is pleased to publish classified advertisements. These are charged at the rate of 10 pence per word—money with order please. It is helpful if you can include a contact telephone number in case of any queries.

Announcements of births, deaths and changes of address will be published free of charge.

Please ensure that these items reach the *Gazette* office four weeks prior to publication.

Guy's Hospital MEMORABILIA

Unique items available only from the Gazette



These high quality cards depicting the Colonnade are left blank inside for your own message. The original oil painting by Clare Walford, a recent graduate, was presented to Dr Scott in appreciation of his 20 years as Gazette Committee Chairman. Cards are available in packs of 10.

Price £10 per pack of 10 + £1 p&p

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Guy's Hospital Gazette
Boland House
St Thomas' Street
London SE1 9RT

I enclose a cheque/PO for £ .....
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ADDRESS: .....
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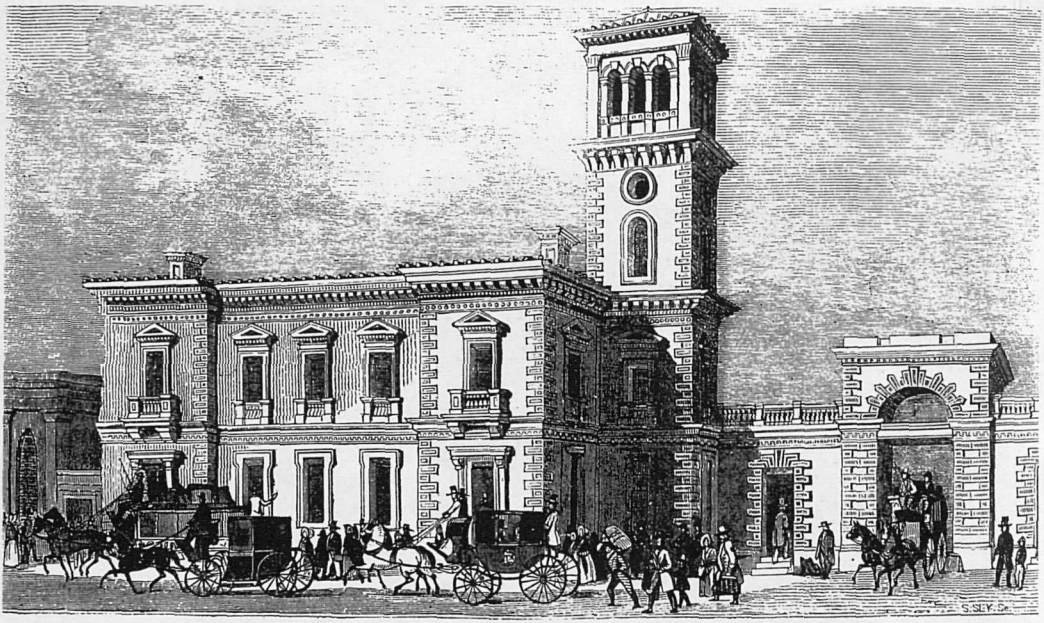
GUY'S

HOSPITAL GAZETTE

UMDS GUY'S
16 JUL 1993

June 1993

- Ethics—the European attitudes
- Abortion—the issues addressed
- Year out—the options



London Bridge Railway Station.

CONTENTS

178 **Passim**
180 **Letters**—Unacceptable attitudes
181 **News**—Dental success
182 **Rag '93**—A diary of the happenings
188 **Ethics**—In Europe
192 **Abortion**—The arguments
200 **A Year Out**—Not doing a BSc
202 **Gazette Interview**—New Chairman of the DLA
206 **Further Muses**—By J H Pitt-Payne
210 **Reviews**—Help for housemen
212 **Dental Notes**—Clinical day
213 **Nursing Notes**—What nurses do
215 **Sport**

Guy's Gazette

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The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

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Passim

The annual general meeting of the *Guy's Gazette* was held on Monday 21 June. Aside from deciding to upgrade our present, somewhat temperamental, computer (something which gladdened the hearts of the editorial staff), the main item of discussion was the formation of the Guy's and St Thomas's Trust and implications of this for the *Gazette*. With the introduction of UMDS, split-site teaching and the amalgamation of most clubs, the sports news and student features have reflected life on both Guy's and St Thomas's. To truly reflect life at Guy's has meant considering it as part of the Guy's and St Thomas's Trust and reporting on the implications of changes and developments on both sites. The *Guy's Gazette* Committee and its St Thomas's counterpart have both been considering the value of publishing two journals within a single trust. We will be sending subscribers a letter, at a later date, outlining the implications of the Trust for the *Guy's Gazette*, possible changes that may be necessary to ensure that we reflect life at Guy's as it is at present, and most importantly, asking for views, suggestions and opinions. In the meanwhile, before 5 August, when the final proposals of the Trust are announced, we welcome any comments you may have. Whatever changes are made to the *Gazette*, we will endeavour to the best of our abilities to keep up the present standards, and publish articles that reflect life at Guy's and UMDS, past, present and future.

Racism at UMDS

Dear Sir,
I would like to bring an experience and my views on it, to the attention of your readers.

On 30 April 1993, a UMDS Rag Hop was held in the Guy's Bar, the theme being an Afro-Caribbean Night. Other colleges of the University hold Afro-Caribbean events, their function being to enlighten us by expressing Black art, music and opinion in an intelligent manner. Indeed, the list of entertainments that night was impressive enough. The problem was that a few people took the occasion as meaning something quite different. The people concerned dressed in ways depicting a number of black stereotypes, the main example being painting their faces black with boot polish. Although disappointed, I was not entirely surprised at what I saw, having previously seen one of the flyers for the event with a face with a bone through its nose (something I find frankly unacceptable). I expressed my concern to some of the people involved, making them aware that their appearance was offensive, not only to me, but probably to many other people who saw them (remembering that the general public eat in the adjacent restaurant). They were strangely surprised at this, evidently unaware of the offence caused and promptly washed the face-paint off. They did, however, think I was being oversensitive, a view many others no doubt will also hold. Some of the arguments in their favour might read,'we were only having a bit of fun', or 'we were giving the event some atmosphere' or even, 'it's all in aid of charity anyway'.

My question is can these arguments be convincingly used as justification for this behaviour? Personally, I think not. These, and excuses like them have been used for far too long.

I am glad to say that it was a minority of people acting in this manner, although I would hazard a guess that many more did not see anything wrong with it. This in my view is tantamount to the act.

I do not suggest that these people are in any way racist. My problem is with their failure to understand the strong feelings that these actions will evoke. Having said this, one can't imagine the scenario occuring if there were a larger number of black students at UMDS. I think in this instance people's understanding would have become crystal clear.

The whole affair left a bad taste in my mouth, so I went somewhere slightly more appealing. Some might say good riddance, but this just means that myself and people like me will avoid frequenting these functions and even these institutions. This had to be bad for Medicine, which if nothing else, needs a multicultural approach.

I hope I'm mistaken, but if these really are the true colours of UMDS, I will be glad to see the back of it.

Yours faithfully,

William Kuteesa
Boland House

The last bastion

Dear Sir,
It was with absolute horror that I learnt of the plan to replace the baths at Honor Oak Park with brand new showers. Is the last bastion of sporting hydrotherapy to be abandoned in favour of some new and ineffective idea from across the Atlantic? I sincerely hope not.

Yours faithfully,

Harry Evans
5th XV Rugby Captain
Boland House

Not a joyous read

Dear Sir,
When I removed my February *Gazette* from its wrapper it was clearly scented, and pleasantly so. Believing that you had accepted the sort of advertising that uses the scented page, I was curious to find out which fragrance company might be targeting your readership. Finding none, I concluded that the colour process used for the cover is itself scented, a practice which is increasing in the printing.

There is another explanation however, which I hope you will take in good heart. The scent had been added as an antidote to the boring ramblings of Dr Pitt-Payne.

Critics of London teaching hospitals, of which I am one despite being a Guy's graduate, are very tired of the anecdotal approach. We live in the present and contemplate the future. Of course history is important, but filling the pages of the *Gazette* with Pitt-Payne belittles your publication and insults many of its readers. Some years ago you were kind enough to find space for an article I had written in tribute to the late Dr. Richard Asher, probably one of the finest medical writers of the century. My effort was called, 'Are medical journals still dull?' I concluded that, unfortunately, they were. And, I am sad to say, still are.

The *Gazette* is certainly not a joyous read. But there's no reason why it should not be. But it will take work. To start with you need to be focusing on now and tomorrow. That is where Guy's future lies. Not in its past.

Get some new stuff in there, especially from the young people with ideas and aspirations for the future. And particularly writers with a sense of humour. Life is too short, and, for many doctors, very dull. The departure of *World Medicine* left little for doctors to smile about in their reading. And there is no reason why humour cannot be balanced with serious reporting about serious issues. Michael O'Donnell achieved it at *World Medicine*. Why not accept the challenge and give it a try?

Yours faithfully,

Neil Watson
3409 White Oak Road
Raleigh NC 27609
USA

Editor- The Gazette aims to provide interesting features that reflect the diversity of its readership. What is received well by some is found dull by others. In gauging how well an article is received we are somewhat at the mercy of the readers and so welcome any comments.

UMDS dental success

Dental students from UMDS have swept the board in a national essay competition. The entries for the Oraldene Essay Prize, on the subject of 'Antiseptic Mouthwashes in Modern Dental Practice, were submitted in November and were judged by Professor Renson of *Dental Update*, Professor Smales of Royal London Hospital and Professor Seymour of the University of Newcastle. Congratulations must go to Miss Tasleem Ahmed, winner of the £500 1st prize, Miss Uchenna Okoye and Shahid Chaudhry who received the 2nd and 3rd prizes of £250 and £100 respectively. A mark of merit was also awarded to the following students in recognition of the high standard of their entries: Mr Bill Ipp, Liverpool, Mr Colin Partington, Manchester and Mr Gladstone Burke from UMDS.

The winning essay has been published in *Dental Update 1993: 20, 3. pp 121-125, (April).*

MSF update

After the article in the April issue of the *Gazette*, Médècins sans Frontières have requested that we print the address of their London office,

Médècins sans Frontières,
3–4 St Andrews Hill,
London.
EC4V 5BY
Tel. 071 329 6939
Fax. 071 329 6936

London Zoo

London Zoo is holding its third event for children (under 18 yrs) with special needs, on Saturday 10th July 1993.

There will be a varied programme of activities, including guided tours, art and crafts, a clown, face painting, games, close-up visits to some of the Zoo's animals, trails, brass rubbing, badge making, pony rides and an 'Animals in Action' presentation.

To apply for tickets, please contact the Education Department, either by writing to Children's Day, London Zoo, Regents Park, London NW1 4RY, stating the number of children (£3), carers (£3) and adults (£5) tickets required and enclosing a cheque made payable to 'Zoological Society of London', or telephoning (071) 722 3333 extension 507.

Rag Week '93 A selective diary

Day 1—Rag begins

With the arrival of an African Bongo drummer imported all the way from the London Underground came the Afro-Caribbean hop and the start of Rag Week '93. The organisers had spent the day assimilating ingredients such as bananas, pineapples, pears, coconuts—whatever wasn't adorning their necks went into the punch bowl. It has to be said that with the cocktails, inflatables, assorted swaree dressers, the 'Bongo Busker' etc it did feel pretty much pseudo-carribean—well as close as you could hope to get in a basement in SE London. The ska band added to the atmosphere, providing light entertainment to a by then sweaty and 'pleasantly confused' population.

Day 3—The rag raid

The rag raid, a daunting feat of organization resulting in a stunning display of surgical greens, took place on the Sunday when 300 UMDS students descended on Brighton in three old-style red double decker buses. A special acknowledgement must be made to London General who lowered their asking price from £320 to £190 per bus after some friendly persuasion from Stuart Livingston. The conductors kindly lent their services free of charge for the day.

It took four hours to reach Brighton, due to roadworks and huge tailbacks but these proved an advantage since major traffic jams meant stationary targets for the collecting pots. The sight of hundreds of greens swarming over cars en route, all indulged in good natured, good humoured, productive collecting was quite something. At every possible opportunity money was raised, from workmen on their JCBs to policemen on the beat.

Even though it felt like Rag '94 by the time Brighton appeared in sight this did not dampen the 'collecting' spirit. It was rumoured that radio 1 warned the public of our impending appearance and in any case anyone on a day trip to Brighton by road that day must have heard rumours of the 'cavalcade' on the way. The weather held and their was unabated collecting from basically anyone and everyone foolish enough to stray into the path of a surgeon. By

the end of the day it was difficult to find anyone who hadn't already been asked.

Thank-you to the good folk of Brighton and those tourists hoping to get away from it all, for their generosity, tolerance and willingness to dig deep.

A good day had by all concerned. We took home sacks of money along with two bicycles complete with tourists, and an ice-cream cone? All of course promptly returned to Brighton before anyone was any the wiser.

Day 5—Hits and happenings

Tuesday was a funny sort of a day, with gaps in lecture theatres and an uneasy expectant feel surrounding the Spit at Guy's and Lusty's at St Thomas's.

For those of you unfamiliar with the 'Hit Squad' let me introduce you to by no means a new phenomenon at UMDS. Gangs of marauding masked men (and these days women) inhabit the Spit and Lusty's for a week and are payed sums of money ranging from £5-50 to 'hit' people. Depending on the price paid, your demise if you are unlucky enough to be targeted, can be something as simple as a bath with shaving foam to penalties far too ghaslty to mention.If that wasn't enough the hits are carried out to the music from the Omen, graciously supplied by DJ Horace, with background screams lent by targets and passers by alike. However this year, the excesses of the Hit Squad were seen to be too harsh by the powers that be, and the hit squads were laid to rest on both sites before the week was up.

Gnoming is a tradition at Guy's and Tommies during rag week and this year saw it take a cartoon slant. If students were unfortunate enough to get handcuffed to a man or woman in a Bart Simpson or Fred Flintstone suit believe you me frustration soon made them pay for release. I don't think the chance Bart might shout 'Aye Carumba' during an afternoon ward round was a risk anyone was prepared to take.

Day 6—The fashion show

You would have thought that after Endurance night the evening before, the animals would go back underground. But no. The Wednesday afternoon MacDonald's eat-a-thon brought them all back out again. Here was a new class of students who at £2.50 a time ate and ate and ate their way through rounds of Mac D's assorted 'foodstuffs.' Who would have thought that so much could be eaten by so few. A striking public display of ferocious greed set in the graceful surroundings of the colonnade.

Wednesday evening brought the culmination of months of hard work.Well, in fact preparations for the Fashion Show had started in March, under the

shadow of part IIa exams. Christina Yu, with help from Juliet Wolfe Barry wrote over 70 letters to assorted companies for clothes and donations but with Easter fast approaching and no replies yet received they finally decided to phone the companies direct and with this came 8 successes. Outfits were provided by:

Zoo, Oasis, Hobbs, Stefanel, French Connection, Puttin' on the Glitz, Kookai, and Esprit with donations generously provided by Coppernob, Hobbs, Classic Clothing Company, Gap, and Alexon. Hair styling was by Ginger Group Hays Galleria and make-overs provided by Make-Up Centre, Bute St SW7.

The organizers barely had time for three run throughs and yet a show was provided by 15 girls and 5 lads worthy of greater praise than can be provided by this short article alone. A fairly daring show including lacy tops, flares and chiffon outfits. The clothes were later auctioned off.

With the main event completed Rag Ball escorts were auctioned by a professional meat auctioneer amid cheers from the continually swelling crowd. Despo Papachristadoulou at £105 and George the Beadle at £200 must have wondered what lay in store for them on Saturday at the Rag Ball.

All in all, a stunning display raising £1300.

Day 7—Roman night

In strutted Smokey Jo Darvesh, compere for the night, sporting jodhpurs, knee-length riding boots, jockey steed and cap. A huge cheer went up from the crowd who half expected a pony to follow in behind.

The main event started slightly later than billed with excessive amounts of money changing hands between race hungry punters and betting staff. In all, 9 races taking place successively on a large screen erected specially for the occasion spawned the usual mish-mash of winners and losers and gave extra meaning to the phrase 'Betting's a mugs game'. But it was all for charity. Not a great financial success but a fun night which in the end did break even.

Toga! Toga! Toga! The final Hop for Rag '93 brought with it Roman slaves, Emperors, Guards, and many white Wolfson-esque sheets. Here was a place where the slave trade had not yet been abolished and the big men fetched worthy prices to be held as slaves at the beck-and-call of their mistresses on the day of the Ball.

Day 8—The rag ball

Southwark Arches is one of South London's unknown treasures. Surrounded by an outside car-park, its painted brick walls, sawdust covered floors and open air drainage set the scene as people clamoured to enter the 3 railway tunnels linked by arches so low that you needed to bend your head to

pass underneath them. The whole venue was ideally suited to the theme of the night, which was medieval, mainly because it recreated the dingy and damp feel of the times. As such it was a haven for lecherous jesters, queens, kings, wenches and monks.

That most people stayed on 'till 3 am is testimony to the fun being had. As the tired and weary spilled onto the streets and headed for home, the rag committee and their faithful friends busily cleared up, though they still found time to sword fight with long loaves of french bread. It was a fitting end to a rag week packed full of excitement and enthusiasm.

Summary of rag week '93

With the frivolities over, we now remember the serious bit. An enormously successful week raising over £35 000 for the Living Image Appeal (responsible for funding of the Britain's National Clinical PET centre based at UMDS), Guy's Microselection Appeal (associated with the oncology department at Guy's and treatment of breast cancer), and St. Thomas' neonatal unit, in desperate need of a Doppler scanner.

None of this could have been made possible without the unbridled support of all around. Without this there would be no event, no rag week and no money. What made rag week such a success was that the events dreamed up allowed collecting to be real fun and catered for many different tastes; from rag raiding Brighton folk to accosting commuters on Westminster Bridge.

Commendation to the rag committee, who undertook a 'humungous' task, shaping a mass of jumbled ideas into a final, formulated, full rag week timetable and who also produced the highly successful rag T-shirts. The organization was not without its problems (snags which hit the hit squad and stopped the selling of the rag mag thought too filthy for circulation).

The evening events were not so much designed to collect huge amounts of money but to provide those involved and around with a great way to enjoy themselves. Even so they still did their bit in carrying forward rag week 1993.

I am sure I speak for everyone when I commend the services of all those who took part, all those who donated, and all those who sponsored. Unfortunately it is impossible to include all the individual names, as you can appreciate the list runs into hundreds. I therefore apologize to all those overlooked, and hope that we, as students at Guy's and Tommies can continue in future years to vehemently support those needy charities, in the good natured manner which typifies rag weeks. The rag commitee:

Chairman C R Davies, Vice chair P Stott, S Livingston, Treasurer O Harley, Activities R Gerber, Publicity P J Zolfaghari, Hops S Rajaratnam, Charities and Sponsorships N Cohen, Collections S Darwish, Rag Ball V Parmenter.

Rag Photos

By Will Norman

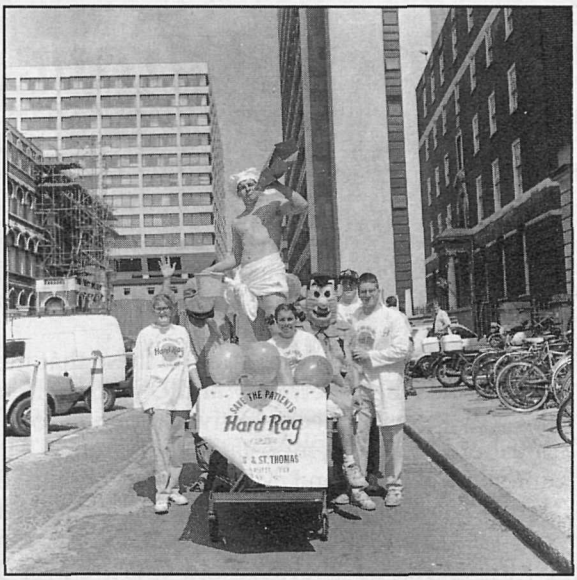
The Fashion Show

Sarah and James

Antonia and Ginny

Juliette and Chris

A
Bed
Push



The
Rag
Raid
to
Brighton

Ethics in Europe

A UMEG and EMSA Evening

What medical ethics were practised in the communist societies of Eastern Europe before their collapse in 1989? What changes if any have been made since and in what way do their ethics differ from ours?

It was to address issues such as these that medical students from Rostock, in the former East Germany and UMDS met on 6-7 May 1993. We were also joined by several Czech elective students from Prague, one of whom, Pavel, contributed to the symposia at short notice. The meeting was arranged as a joint venture between UMEG (United Medical and Ethics Group) and EMSA (European Medical Students Association). The first evening concerned abortion, the second, HIV and confidentiality. On behalf of UMDS, Roxanna Gunny discussed abortion and Mark Dayer HIV. Both presentations addressed these topics from the perspective of UK law and ethical guidance, giving some indication of current controversies. Both presentations were excellent.

Abortion in East Germany

Felix from Rostock spoke on both subjects. On the question of abortion, Felix first described the law before unification. In the German Democratic Republic (the East), the 1972 Abortion Law guaranteed abortion on request. The Law statedthat in, 'self determining the number and the time when to have children, every woman has—in addition to other available methods of contraception—the right to terminate a pregnancy'. Three conditions were stipulated:

the gestational limit was 12 weeks

second trimester abortion had to be on medical and eugenic grounds only (presumably 'eugenic' refers to foetal abnormalities)

abortion had to be carried out within the Gesundheitswesen der DDR (NHS) and was part of a doctor's duty

Felix observed that certain social conditions discouraged abortion on the grounds of maternal poverty. For example, 85-90% of women were employed, while inexpensive kindergarten places were only available for children over the age of one year of age.

Unification of East and West

With unification in 1990, section 31 of the treaty between east and west stated, 'It shall be the duty of the united German parliament to find a solution for the protection of developing life and—according to the constitution of Germany—to come to a conclusion on how the conflict of pregnant women can be managed. The emphasis shall be placed upon statutory rights of counselling services and social support, thus creating a situation which is substantially better than those persisting in both parts of Germany'.

This aim led to the 'Protection of Developing Life, Promotion of a Child-Friendly Society, Pregnancy-Conflict and Abortion Act'. This includes provisions for:

sex education

abortion on request after mandatory counselling (special counselling services set up throughout the country)

statutory right of a kindergarten place for every child from the age of three

maternity leave (up to three years unpaid)

building of council-houses and flats for women and families in need

conscientious objection for doctors and nurses

The act was passed by a narrow majority in the Bundestag in autumn 1992. However, a group of conservative MPs together with the Free State of Bavaria succeeded in temporarily stopping the new law through the Supreme Court, with the final decision, predicted for February '93, postponed. Felix described how there is no consensus within or amongst political parties nor the churches, with a north-south and east-west division also apparent.

In the current debate, anti-abortionists argue that the state has a duty to preserve developing life, and that medical indications for abortion should be rare exceptions. Pro-abortionists argue that criminalising abortion is counter-productive for changing women's minds; abortion will take place anyway, and regulations are what are required. Fundamentally, the state must not act as a guardian of women. Felix concluded with two questions, 'Will we accept that we cannot agree on one ethical code?' and, 'Are we willing and can we find a compromise that will improve the situation of women in Germany?'

Felix's contribution was highly informative and thought-provoking. Pavel from Charles University in Prague was invited by Roxanna to give the Czech view on abortion, and he amazed us all be standing up and speaking at length without preparation about the law and guidance in his country.

The Czech perspective

Pavel explained that the former communist law established special committees in each local authority to deal with abortion for 'social' reasons, usually

meaning 'on demand'. A recommendation from this committee was necessary for the abortion to take place.

This practice was changed in 1986 when a new, more liberal law was adopted. This law is still valid and enables abortion 'on demand' until the 45th day of pregnancy (counted from the last menstruation), abortion on medical and social grounds (eg rape) until the end of the first trimester, and abortion on especially severe medical conditions until the end of the second trimester. 'Medical indications' include foetal malformations as well as damage to the mother's health. Pavel described how this new law was associated with an increase in the number of abortions, with the incidence of abortion almost equalling that of live born children. This high incidence of abortion is linked to poor sex education and low use of contraception (only about 20% of women regularly use the pill).

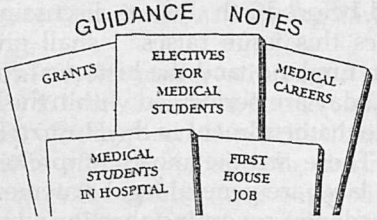
A significant change emerged in 1993 with implementation of compulsory health insurance which covers abortion only on medical grounds. Given that the cost of abortion 'on demand' equals half the average monthly salary in the Czech Republic, women will clearly have greater disincentives for abortion.

Pavel concluded with the observation what while many people express concern about the high numbers of abortions, a radical change to the liberal law to restrict the indications for termination is probably not politically feasible.

Both symposia were followed by receptions in which we were able to meet and talk more informally. The Germans stayed over the weekend to attend the Rag Ball. Having attended numerous previous meetings of the Ethics group, I appreciated how much more participative the audiences were on this occasion, especially on the second evening, when we were no longer in the beautiful but very format setting of Governor's Hall. I think this perhaps may be because student speakers seem less daunting to question and dispute with than eminent professionals. This is something that I hope future meetings of UMEG will take consideration of as audience opinons and discussion really make the evening worthwhile.

Quinton Deeley
Chairman UMEG

BMA



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Abortion

The issues involved

Abortion, according to the lay interpretation of the term, is the destruction of life after conception and before birth. Before discussing the questions of morality and ethics this issue raises, I shall give an overview of the current legal position in England, and the historical context in which it arose. The legal abortions of today are performed within the limits of the 1967 Abortion Act, and a subsequent amendment in the Human Fertilisation and Embryology Act of 1990. These are the most comprehensive statements since statutory laws (statute laws are general legal statements as opposed to case laws which set legal precedents) governing abortion were first passed in England, from the early nineteenth century onwards.

Historical background

Until the sixteenth and seventeenth centuries, abortion had been regarded as an ecclesiastical offence—the crime being the denial of eternal life to the soul of the unbaptised foetus. But then, with the abolition of the ecclesiastical courts during the civil war and the growing tendency of making ecclesiastical offences statutory felonies, abortion became the province of the common law. In the eyes of this law, abortion was a misdemeanour capable of being committed by the pregnant woman herself, or by other people, but in either case, only provided the stage of quickening (i.e. the time at which foetal movements could be felt) had been reached.

Significantly the nineteenth century marked the first period of statute abortion legislation. This may be seen in the context of developments within medicine itself, as well as an increasing recognition by governments of a parliamentary role in the maintenance of the populations health. The eighteenth century had witnessed the rise of obstetrics and gynaecology as a field of medical expertise. The pregnant woman was now being cared for by the learned male accoucheur rather than the traditional midwife, a trend which was continued in the nineteenth century by the professionalisation of medicine and the exclusion of unorthodox, untrained healers from medical practice.

1861-Life preservation act

The new laws, made and enforced by men, overrode traditional reliance on

women's immediate experience of fetal movement as a meaningful stage of development, and, with the 1861 Offences Against the Person Act, designated women as criminals for any interference in their own pregnancy, for the first time in statutory law. Of all the legislation of this period this Act is the most important as it remains in force to this day, being used to prosecute those carrying out illegal abortions. This law made it a serious offence, 'unlawfully to administer any poison or noxious thing or to use any instrument or any other means whatsoever'; subsequent laws have amended this statement to define certain abortions as being 'lawful'.

1929-Infant life preservation act

The 1861 Act, however, had left a gap in respect of the child who was in the process of being born. Before birth, the Act made the destruction of the foetus a serious offence. After birth, destruction of the child, its existence independent of the mother, was covered by laws on homicide. Thus, in 1929 the Infant Life Preservation Act was introduced which created a new offence of 'child destruction' or infanticide. This is a non-capital offence and remains the law today. Importantly for today's legal abortions, this was the first time the concept of viability was mentioned, an ethic upon which current law is founded. Infanticide is a crime committed when an embryo is destroyed at 28 or more weeks gestation, ie when the embryo is viable. Destruction is permitted beyond this to save the mother's life.

To summarise, abortion before 28 weeks, for whatever reason, was covered by the 1861 Act and was the serious offence of felony, abortion after 28 weeks for any other reason than to save the life of the mother was the crime of infanticide, and the destruction of a child after birth the crime of homicide.

Born alive or the potential to survive?

On of the key phrases in this Act from which controversy arises is, 'the destruction of a child capable of being born alive', which is not synonymous with that of a child 'capable of survival'. For the purposes of this Act it was taken to mean 28 weeks onwards.

In the past, this has been a target for attack by anti-abortionists since one approach would be to redefine when exactly a child is capable of being 'born alive'. This is effectively what the 1990 Human Fertilisation and Embryo Act has achieved by, to all intents and purposes, reducing the legal period of viability to 24 weeks onwards by an additional clause to the 1967 Abortion Act. Some anti-abortionists have taken this further since one could argue that an unborn child which is not capable of survival is still capable of being born alive.

Interpretations and implications of 1929 act

Confusion as to the exact implications of the Infant Life Act remain to this day. In 1983 a doctor was charged with the attempted murder of a child, the result of an abortion in which the child was born alive, and in such the doctor failed to intervene. The child received treatment and survived. A charge of infanticide could not have been brought against the doctor since there is nothing in the Act about any intent to cause child destruction, only the outcome of the procedure, which in this case was not death. And yet technically the 1929 Act should have covered it because the foetus turned out to be viable. Of the offence with which the doctor was actually charged, that of homicide, he was acquitted; but had the child died he would have been guilty of infanticide. So you can see just how confusing it is.

Meanwhile in the period after the Infant Life Act was introduced, abortion controversy continued. Some judges who were sympathetic to the eugenic arguments of the 1930's, that national strength would be depleted by the unrestricted breeding of the working classes, were giving excessively lenient sentences by the standards of the day. It was argued that the 1861 Act was irrelevant; with advances in medicine, such as the introduction of dilatation and curettage and antibiotics, at least one of its assumptions, that abortion was a grave risk to maternal life, was no longer applicable. Indeed by driving the operation underground the law served only to endanger maternal life by unsafe abortion, rather than preventing abortions from occurring.

What is unlawful? The 1967 abortion act

With cases such as that of Rex vs. Bourne 1938, interpretation of the word 'unlawfully' in the 1861 Offences Act with its implication that some abortions are 'lawful' or legal, was questioned. Through such test cases, the consideration of preservation of the mother's life was expanded to a broader assumption of danger to life, then danger to health, including mental health. Since case law is never as satisfactory as statute law, a number of Bills were presented with the aim of making this a statutory category. The result was the 1967 Abortion Act which is the basic legal position today. In this Act, there are four clauses which allow abortion:

the risks to the pregnant woman's life
risks to her physical or mental health
risks to her existing children
risk of having a handicapped child.

These clauses are fraught with problems. For example, the wording in the first clause, that abortion is legal if the risk to the life of the pregnant women is greater than if the pregnancy were terminated is unfortunate. As the 1988

BMA ethics handbook points out, the risk of injury to the health of a woman is statistically smaller if a pregnancy is terminated in the early months than if it is allowed to go to term. Some may use this fact to argue that abortion is justified if the woman requests it although technically this is not abortion 'on demand' since there is a 'conscientious objection clause'; the doctor's legal duty is to refer the woman to someone who is willing to perform the abortion.

Considering the risks to the pregnant woman's health, how big should this risk be? Significantly, this is the most frequent clause cited on abortion certificates and, for example, the lack of comment on the degree of damage to mental health, allows for the widest possible interpretation between two extremes, between the claim that there are no psychiatric indications for abortion and the claim that even minor worries and unhappiness constitute injury to mental health. A point to mention here is the controversy over exactly what is mental health, since the very idea of the existence of mental illness has been questioned by some individuals.

The third clause which in effect allows abortion for the sake of others implies that maternal and foetal health are not the central issues; indeed both may be perfectly healthy.

The risks of having a handicapped child is the clause invoked in one to two in a 100 cases. The terminology is vague and the exact meaning of 'substantial risk' and 'seriously handicapped' have never been tested in court; one problem is the difficulty of assessing whether a fetus is actually affected since the abortion of perfectly healthy fetuses is one of the issues at stake.

Other ethical dilemmas are raised by this clause. The Act clearly permits, and, it may be argued, condone the selective abortion of an abnormal foetus if the pregnant woman feels unable to cope with the upbringing of a handicapped child. On the one hand this may be seen as the avoidance of unnecessary suffering and is consistent with a quality of life ethos. Thus the law is subscribing to a particular ethic here and may be contrasted with the alternative view, that of the sanctity of life principle. This says that all life is precious and that selective abortion promotes a eugenic philosophy which regards all less-than-perfect human beings as inferior.

1990-human fertilisation and embryology act

The most recent piece of abortion legislation is the Human Fertilisation and Embryology Act 1990. The new addition is the time limit of 24 weeks to the clause encompassing risks of injury to the physical or mental health of the woman. It complements the 1929 Infant Life Act by implying that between 24 and 28 weeks, when the Infant Life Act takes over, abortion is only permitted on the grounds of grave and permanent injury to the woman, the continuation

of the pregnancy involving greater risk than the termination—at this stage the risks of continuing to term are not in the average, healthy pregnant woman greater than the risk of the abortion, unlike earlier in the gestation. Effectively this reduces the period of gestation at which the majority of abortions for 'social reasons' though couched in terms of medical risk, may be performed to 24 weeks.

Continuum of life or humanity from conception?

Clearly the law has adopted one particular ethic in the abortion debate—that in foetal development there is a continuum of humanity from the fertilised ovum through to the fetus at term, and that the cut-off point for when the foetus is accepted as human, (rather than having human potential), is the point at which it becomes viable, ie, when it is capable of survival outside its mother's body. However, many groups do not accept this continuum-of-life approach, and others who do would question viability as a cut-off point, on the assumption that if, at some stage, a foetus possesses humanity we must accord it human rights, including the right to live.

The traditional Catholic view, for example, which recognises the onset of humanity from the moment of conception, refuses to discriminate among human beings on the basis of their varying potentialities. This ethos is applied equally to the potential of the fetus. To quote a catholic theologian, ' If you are conceived by human parents you are human'.

The problem with the continuum-of-life perspective is than in order to pick a suitable cut-off point as to when the fetus is human, rather than potentially human, one must define what it is to be human and what level of developing humanity can and ought to receive human protection. A definition something along the lines of 'the ability to experience, to remember the past and to envisage the future' seems reasonable enough. There are different arguments, for implantation, two to four weeks when it first becomes differentiated enough to be considered a unique and unified individual, when it looks human—with arms and legs, when it has electrical impulses from the brain, when its mother can feel it moving, when it is viable, or at birth, as suitable cut-off points. Apart from the arbitrariness of these as markers of humanity, though, history tells us that the claim that people of different races, religions, physical and mental abilities are less-than-human has been the justification for slavery, witch-hunts and genocide. Indeed, the policy of selective abortion of pre-natally diagnosed abnormal foetuses is seen by some as 'antenatal euthanasia', and may be seen to undermine the very right to existence of all such handicapped people in the world today. This concept of humanity as a yardstick by which to measure both anti- and pro-abortionist views is flawed.

Is abortion killing?

Perhaps another approach to the abortion question is applicable. Is abortion an act of killing at all, and do the usual reasons for protecting life apply? Firstly, what are the effects of killing? This may seem an obvious question, but it is relevant if one argues, as some have done, that at a particular stage in fetal development, the criteria for killing are not fulfilled and therefore that the destruction of the fetus is acceptable. In considering this argument that the foetus is not yet capable of being killed, let us consider what killing is. As regards the victim, the threat of killing causes suffering, the act of killing causes suffering and the experience of life is considered so valuable that no-one who has this experience should be deprived of it. As regards the perpetrator, killing is brutalising and criminalising. And finally, killing causes suffering to family and friends.

Consider the fertilised ovum or even the early cell mass at four weeks. This group of cells cannot fear death, since it is not conscious of the impending loss of life, indeed it is not conscious of this experience of life at all. It cannot feel pain or suffering in the act of killing since embryology tells us that the foetus's brain does not receive electrical impulses at this point. If the abortion is desired by both parents, there will be no grief comparable to that caused by the loss of a child. All that is being removed is the potential experience of life; this is enough to make the act of abortion something considerably more than cutting one's hair for example, but is not sufficient to equate it with murder in that this act does not fulfil the previous criteria. However, this sounds familiarly like the humanity argument, that at some point the foetus is human from which it deserves protection of its life, in its claim that at some point the foetus can be killed.

Conflict of rights

In discussing the morality, it is apparent that the primary conflict is that between a pregnant woman and the unborn life she nurtures. Those who oppose abortion focus on the rights of the foetus, either through claims that all life is sacred, that humanity must be protected and that life which is similarly potentially human has similar rights. A midway approach is that suggested by the continuum-of-life principle, that at some arbitrary point a foetus becomes human enough for its life to be worth protecting, which seems to be the basis of our law. Those who support abortion focus on the mother's rights.

The Women's Rights arguments rests either on the woman's right to self-defence or of her right to control her body, since it belongs to her and no-one else. If it is accepted that self-defence is allowed to justify killing an innocent

person, a philosophy with which some would disagree, then the claim that, when a pregnancy threatens the mother's life, she has a right to self-defence even at the cost of the life of the foetus is a powerful one. But in less extreme situations, the fact of mere ownership of the woman's body as an argument that she and she alone may determine what happens to it and seeing the foetus as simply an extension of her body, is flawed. Apart from the dubious concept of viewing the woman's body in this context, as a piece of property like say, a piece of land, mere ownership does not give the right to kill innocent people on that property or even to expel an innocent person from that property when doing so will result in his death.

The rights of the foetus

The priority argument, which is connected with a woman's rights over her own body but also with a distinction between help that a decent person will give and help that someone has a right to demand, is an interesting one. It may be argued that the foetus only has a right to the use of the woman's body if the mother has assumed a special responsibility for it—that is to say, pregnancy was a voluntary choice. In this case, she would have an obligation not to withdraw support, unlike a situation in which a foetus was conceived despite all reasonable contraceptive precautions, and was unwanted. When the fetus has no rights, to continue to support it may be seen as an act of charity rather than performance of a moral duty. The advantage of this ethic is that it allows the individual situation to be considered rather than making a blanket statement on all abortions. But, and this is a big but, do we only have duties to people when we have voluntarily accepted them? Surely we have negative duties, that is, not inflict harm, to everyone whether or not we have deliberately accepted this responsibility.

As you can see, there are no clear cut ways of treating the subject. My own feeling is that each one of us has a view on abortion which does not stem from a logical, consistent appraisal of the arguments for and against but from our own emotional response to what life is and our own experiences of life determine how much weight we give to the rights of the mother versus those of the foetus, and vice-versa. Within this battleground of opinions, the law serves as a guide between two extremes; it is not there to enforce one particular ethic at the expense of all others, but in its adoption of the ethic it has, it allows women and doctors to rely on their own personal values.

Roxanna Gunny

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A Year Out

An alternative to a BSc

Just what is the attitude of the medical school to students' requests for a break in their studies? Having been granted a year off myself, I can tell you that the authorities are surprisingly amenable—if, of course, you have a feasible, well thought-out plan for your sabbatical. Informing the Dean that you are off to stack shelves in Sainsbury's for a year may not go down well.

With this in mind, and the present second years at the stage in the curriculum where a high proportion take a year out of the MBBS course to do a BSc, I asked Dr Hywel Thomas, the Pre-clinical Dean, for his thoughts on the subject.

Dr Thomas, on what grounds would you allow a student to take a year's break?

Well, we are very much in favour of students taking a year off. If students are progressing on the course, but still feel that instead of doing a BSc they would like to travel, their decision is welcomed—if they have a sensible plan.

I tend to look for someone who wants to learn a new skill of language, or a student who would like to learn about Information Technology or acquire an extra qualification. The year off must be a constructive experience, requested formally, and should come as a 'natural' break in the course, between the pre-clinical and clinical years.

How many students each year request a year off?

A few students each year have need of a break due to family problems such as illness or bereavement. Apart from this compassionate leave, about one a year leaves to do a language course or voluntary work for instance. Recently a student left to study for a diploma in Theology and at the moment one student is researching in Italy.

Does taking a year off affect future chances of employment?

No, not having a BSc qualification has no effect on your job chances. A student's firm grades and clinical competence are more important.

Is this opportunity offered in other medical schools?

Yes, I think so; the need for a break is natural in a five-year course and I feel that the only reason more studentsdo not take a year out is because they cannot afford it.

A year in China

Steven Chan, a first year clinical student, took last year off to study Chinese in Beijing. I asked him what he thought he had gained from the experience.

Steven first approached his clinical adviser and then wrote to Dr. Thomas to request his permission to take the year off. Once in Beijing, he spent eight months at the Beijing Teachers' College; the qualification he now has is considered to be equivalent to a BSc. He would recommend taking a year off on the as there is a lot to be gained personally and feels that he came back to medicine refreshed and enthusiastic about the clinical course.

A Year in India

Taking a year away from the medical school course does not necessarily mean having to spend it acquiring a written qualification. The time can be spent learning and experiencing an entirely different way of life, perhaps gradually acquiring a new language. I spent my year away from UMDS in India, travelling around on my own, exploring a totally different culture, truely putting my resourcefulness and independance to the test. It was an unforgettable experience, and one which definetly enriched my student years.

Orna McGinn

Professor Rodney Grahame

New Chairman of the DLA

Professor Rodney Grahame, Professor of Clinical Rheumatology, UMDS, and Consultant Physician, Guy's Hospital has been appointed the new Chairman of the Disability Living Allowance Advisory Board, from 5 April 1993.

The Disability Advisory Board

This Board advises the Secretary of State for Social Security on the Disability Handbook, which explains how medical conditions are likely to affect mobility and care needs. The handbook assists adjudication officers in dealing with claims for a Disability Living Allowance (DLA) and Attendance Allowance (AA). This was introduced in April 1992 as a means of providing people below the age of 65 with help with the extra costs of their disability. Nearly two million people are currently receiving the allowance. The Board, which includes people with disabilities and a carer, as well medical practitioners and those with specialist knowledge of social work, occupational therapy, physiotherapy and nursing, also advises on some individual claims arising from particular medical conditions.

On announcing the appointment, Nicholas Scott, Minister for Disabled People said, 'Professor Grahame brings valuable experience to the Board not only from his work at Guy's but also his close association with the British league against Rheumatism and many other organisations working for people with arthritis and rheumatism. I welcome his appointment and the important contribution he will make to the work of the Board.'

Professor Grahame first came to Guy's in 1969. He trained at The London Hospital Medical College (1950-55), where he also did his pre-registration house jobs and spent 18 months as an SHO. He then worked for five and half years in General Practice, on the Camden-Westminster border, a time he feels gave, 'insight into the medical needs of the community and the importance of primary care.' Professor Grahame returned to hospital medicine , via Hammersmith hospital,to train as a Specialist in Rheumatology and General Medi-

cine, gaining an,'appetite for scientific enquiry' and developing a method for measuring the elasticity of human skin 'in vivo' which led to the award of a MD (Lond) degree.

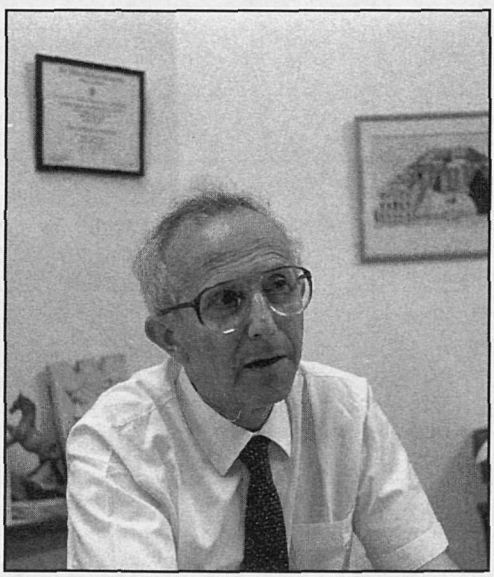
Rheumatology at Guys

In 1969 the then Department of Physical Medicine was a busy and well-endowed clinical department but rather remote from the rest of hospital and medical school life. Over the next ten years the situation changed remarkably, with access to all medical students via attachment to a general medical teaching firm and also a high profile in research.

In 1973 Professor Grahame became the first director of GARU, an inter-departmental Medical School body, set up to promote and co-ordinate research in arthritis and related conditions, on the Guy's campus. The success of GARU, 26 international meetings and 159 papers in five years, was one of the factors which influenced the ARC (Arthritis and Rheumatism Council) in 1979 to make a grant of £½ million to endow in perpetuity a chair in Rheumatology at Guys. This gave the department new impetus and following the appointment of Professor Panayi expanded research into areas of cellular immunology and immunogenics.

Professor Grahame has been senior physician and responsible for the day-to-day running of the department of Rheumatology since 1976. Over the years the department has set up many special interest clinics, such as Ankylosing Spondylitis, Athletic Injuries, Slow-acting Agents, Problem back pain, Psoriatic Arthritis and most recently Soft Tissue Injection for General Practitioner Education. It also recently began a project, funded by SE Thames RHA, exploring the role of the Rheumatology Nurse in primary care.

The diversity of interests of the department is seen also in Professor Grahame's personal research which ranges through the pathogenesis, treatment, implications



Professor Rodney Grahame

and rehabilitation of rheumatic disease. His special interest over the last two decades has been the physical and biochemical abnormalities of connective tissue and their sequelae. He is also actively involved in post and undergraduate teaching, making a department which is accessible (and friendly) for students.

Extra-Guy's Activities

For 10 years up to 1988 Professor Grahame served as Honourary Medical Secretary of the ARC. He is a past editor of the British Journal of Rheumatology (1982-1985) and the second President of the British Society for Rheumatology. Commenting on his appointment as the new Chairman of the Disability Living Allowance Advisory Board, Professor Grahame said 'The problems of people are many and varied and I shall welcome the opportunity to be so closely involved in the work of the department. I shall be helping adjudication officers understand the needs of people more fully and the likely effects of their conditions. I am greatly honoured to be appointed to this all important responsibility and I greatly look forward to this new challenge'.

Romila Bahl

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Further Muses

by J H Pitt-Payne

I never cease to wonder at the triumph of the human spirit in the face of adversity and never was this made more clear to me than with a recent case. The man in question, well into his eighties with not much further to go due to secondary cancer and impending bronchopneumonia, had become somewhat weakened by his illness. In only 36 hours or so he would pass onwards into the Cosmos. His two sons had to get him out to the commode and whilst he rested there, they made the bed and tidied things up a bit. Their father was then stood up but lost the use of his legs, which led to considerable problems as neither son had been used to handling what amounted to something of a dead-weight. After some futile manoeuvres they all landed on the bed together with the father in the middle. Though bereft of his dentures and further weakened by these actions he said to them—quite audibly, 'And what are we going to do for an encore?'

Counselling the dying is no easy matter and is a test for all of us, I'm sure. This man proved to be no exception. The previous day he had said to me,'So - I just have to lie here until it happens—eh?'

'That's about it, sir.' Then there was a pause and he said, 'When?'

'Whenever you're ready.' I replied. There was a further pause as he considered my reply.

'Why?' His question shot forth like a bullet from a gun. I had to think rather quickly.

'Why not?' I countered. He gave me one of those looks and then said,

'Well - that wasn't a very long conversation.'

'They weren't very long questions.' I suggested. The following day I told him how I thought things would go—and the things went as I had thought they might as he sank into the arms of the 'old man's friend' and succumbed in the early hours of Easter Day.

Syringe drivers an a dotors lot

What a nice thing to be able to die in one's own bed, free from pain and not a syringe-driver in sight. Not that I have anything against them but they are thirsty beasts and their need for hard drugs is somewhat more than local chemists can usually manage. Doctors who got it a bit with the controlled drugs tend to get rung up by the Home Office Drugs Inspectorate, and, though

ever courteous, their enquiries give me the willies because it all smacks of 1984 and Big Brother watching me. However, I continue to comfort myself with the thought that if I am paranoid that doesn't mean that 'they' won't get me!

The realities of life

Happily, reality is all to apparent as may be evinced from a situation where I was anointed by the contents of a commode, which, it seemed, had become somewhat over-full for reasons that remain totally obscure and completely mysterious. The Matron of the Nursing Home in question was present at the time the 'incident' occurred. The patient in question, a woman with Parkinson' Disease, needed what I might have alluded to in those days as my total attention. Accordingly, I saw the only other chair in the room, and, assuming that it was a chair, I sat on it and then lifted it up by the arms and shuffled forwards a few paces. What happened next is far too disgusting to mention in the pages of this august magazine but the 'contents', such as they were, proceeded downwards along the rear creases of my very smart trousers and then filled both shoes until they over-flowed onto the carpet. So intent was I on gaining the patient's attention, I did not realise what was happening until the deed was done. The biological nature of the contents of what I now realised was a commode made themselves known to me by means of an effluvia with which we are all acquainted. Whether I uttered a strangled cry or not has, thankfully, left my memory but the Matron—still a very good friend was helpless with laughter. As for the woman with Parkinson's Disease, she too was as convulsed with mirth as it was possible to be. Somehow, I kept what was left of my composure and declared that I would have to go home and change my clothes—which I did. I had had two pairs of trousers made for the suit I was wearing at the time and it was the work of a moment to discard the trousers, socks and shoes, and put on their replacements. My wife, Jaqui, washed out the shoes, sent the trousers to the cleaners after a mandatory soak in some Dettol together with the socks. I told my father what had happened, and instead of being concerned, he too found it highly amusing and proceeded to tell every patient he saw for several days afterwards—and for years after that!

Further anointments

As I went on in General Practice I was to be anointed further. There was a very sick old man two roads away from me, and I had taken on some of the chores associated with keeping him at home. As ever, the District Nurses were excellent but they would give him laxatives which seemed to be effective at the most inconvenient of times and he would ring me and request my presence

as quickly as possible. I was invariably quick off the mark but somehow he never made it to his destination and I would come home in a somewhat ill humour, shouting at my wife as I came in through the door, 'It's happened again!'

'What has?'

'These trousers!' I'd explode. 'It's just not worth while wearing decent clothes anymore!'

Colleagues may wonder as to why I was answering the calls of nature which were not mine to own—but such was my zeal in those far off days that nothing appeared to be too much trouble. My trousers were constantly under threat and there was a patient who summoned me one Saturday morning. He was somewhat addicted to the fruit of the vine and he was also possessed of only the leg; the other having been lost during the War. When I entered his bedroom, I went to the bedside; taking in as I did so the artificial leg with its shoe and sock on. I was so taken with the thought that the leg might come to life and kick me that I can't have been concentrating as I knelt by his bedside effecting what amounted to my developing bedside manner. In no time at all I knew I had knelt in something terribly wet and I don't have to tell my reader what it was. Yet another journey home took place as I changed my trousers.

Small wonder that one of my favourite characters in 'Beachcomber' was 'Big White Carstairs' whose fool of a manservant had forgotten to pack his dress trousers when he went to Africa; thus making it impossible for Carstairs ever to attend dinner until a new pair had been made. As you will remember, he was forever staying in his room making excuses as to why he was unable to appear for dinner. Me and 'Big White Carstairs' seem to have had a lot in common!

Bags and bottles

Out in the styx of General Practice, there are sometimes a few surprises. One day a Zulu Bishop came to see me. I remember him well because he had a urine sample with him—which he had brought in a Harrod's bag. Somehow, whenever I saw a Harrod's bag after that I always associated it with samples and one day a woman had such a bag in her hand and I took it from her saying as I did so, 'I'll take that.' She sat down whilst I removed the carton from the bag and unscrewed the top. 'It's chocolate spread!' I announced somewhat blankly.

'Yes.' said the patient. 'I bought it in Harrod's! Only I didn't like to say anything.'

Then on another occasion I opened a similar carton assuming it was a urine sample but the bouquet was entirely at odds with my expectations.'Crikey!' I

ejaculated. 'What the hell have you been eating? I mean to say—this is yours—isn't it?'

There is a paper waiting to be written on the subject of containers but I give thanks for the humble plastic bag, preferably the ones that don't have air holes in. Many's the time that the yoghurt carton supposedly sealed with clingfilm has mysteriously emptied itself into the plastic bag. The worst nightmare scenario is the dripping bottle handed to me by the seemingly unaware patient who claims they have no idea it 'Had a hole in it, doctor'.

Screws and such like

I had a patient once, who had had stereotactic surgery from the brain surgeons in Edinburgh. Their efforts had not been terribly successful and her Parkinson's Disease had taken her into a Nursing Home, funnily enough the same Nursing Home as mentioned before, the same Matron—and the same patient! One day, she had been feeling the back of her head and she felt something hard. The Matron could feel it too, and in due course I was invited along to take a look. What it was surprised me: it was a small gold-coloured screw.'You've got a screw loose!' I told her.

'You're joking!' she replied.

'No—it's definitely a screw.' I insisted. Using my modified sebaceous cyst technique I delivered this piece of technology through the small hole it had made in her scalp. It was a 5mm screw . I've never seen anything like it in my life.

This really brings me back full-cycle to the syringe-driver which relies on such a thing within its works to drive the plunger forwards. In a way, I see it as the ultimate screw because it is the last piece of technology to be used on a large number of patients.

J H Pitt-Payne

Help for housemen

A Handbook for the Houseman. D Baldwin, K Hopcroft. Second Edition. Blackwell Scientific Publications 1993.

This is the second edition of a useful 'white-coat, pocket-sized' book. Its aim is to ease the transition from carefree medical student to hassled, embittered house officer. The first few days and weeks after qualifying are certainly fraught; I am still surprised at the extent to which five years of training can leave one so thoroughly unprepared for the job one actually undertakes. Unless you have endured a locum appointment as a student, or have dogged the footsteps of a houseman, you will be astonished by your first day of employment. It is not that the job is intrinsically difficult, it is just that there are many systems and protocols to learn; writing drug charts, ringing laboratories, chasing results, filling in discharge summaries, certifying the dead, preparing theatre lists, bargaining for CT scans. There is a myriad of new tasks to face, and many different ways of achieving each. Most people learn by bitter experience, but there is still a lot to be gained by reading a book such as this before 1st August.

It is concisely written and covers most of the vexatious issues. It is full of useful, practical advice which, in my experience, was of great value in my first days and weeks as a house officer.

It cannot, of course, provide all the answers, and there is still no alternative to experience, but if nothing else it will help to clarify your fears. I strongly recommend it.

Tim Plunkett
House Officer

History of medicine

Richard Bright 1789-1958. Physician in an age of revolution and reform. Diana Berry and Campbell Mackenzie. Published by the Royal Society of Medicine, London, 1992.

Guy's hospital is justifiably proud of the man she regards as probably her greatest son, Richard Bright. However this book is a reminder that we share his greatness with Bristol where he was born and raised and Edinburgh, where he received his undergraduate education. The two authors of this outstanding book are Bristolians, and both worked on the local historical aspects of the Bright family's life in Bristol before beginning the book. Campbell Mackenzie, the physician of the team, a Scot who retired only recently from running the Richard Bright Renal Unit in Bristol. As I write he is crewing one of the yachts in the round the world race back to the UK from South America.

To have co-authored such an outstanding book as this as well is evidence of breadth of talent indeed!

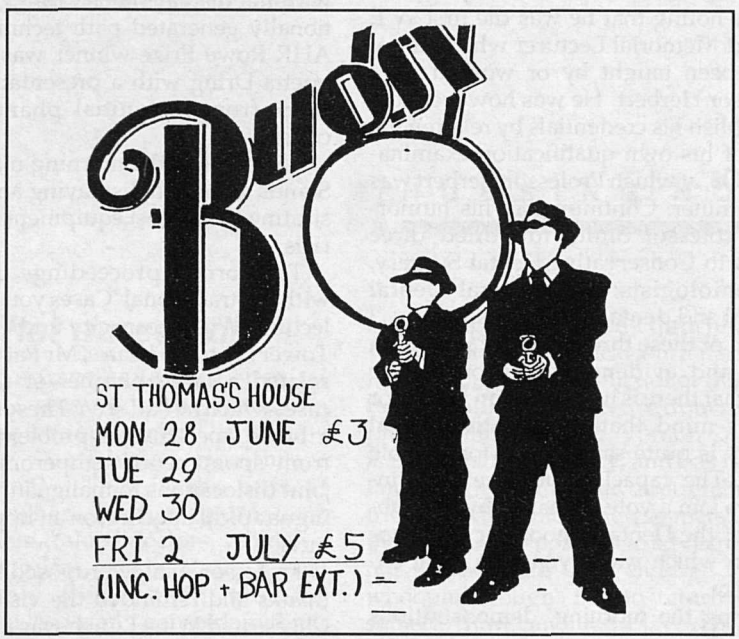
Although many articles on Bright are available, a number in old issues of the now defunct Guy's Hospital Reports which Bright helped to found, no full-scale biography of Bright has been attempted since Pamela Bright's intimate portrait of her great- great- uncle was published 10 years ago. (Dr Richard Bright. Pamela Bright, Bodley Head, London 1983). Berry and Mackenzie's view is a much broader one, as the title of their book suggests, placing Bright in his professional and historical context. As well as all the usual records, both Pamela Bright and the present authors have been able to draw on a priceless series of letters, from a family addicted to written communica-

tion and carefully preserved in the Bright archives, much now stored in Melbourne University Library as a result of efforts by Dr Robert Kark—a Guy's man who is himself working on a biography of Bright and Peter Bright, a reputable vintner.

The fascinating book brings alive the medical school and the medical scene of the early nineteenth century, when to study in Edinburgh was the acme of education that Europe has to offer. Bright was, as a member of a dissenting family, unable (like Hodgkin) to study science at Oxford or Cambridge. Then there were the travels, Iceland, then Hungary (during which Bright 'dropped in' on the Congress of Vienna), as well as the whole social scene and the bustling life of London. In the midst of all this—tragedy: the loss of his young wife and his near death from typhus.

All this the authors bring before us with vivid prose. One cannot open the book at any page without finding a titbit of information which arouses interest or excitement. Anyone who has trained or worked at Guy's should buy this modestly priced book, the better to understand something of the tradition of an institution which, alas, is currently under threat from men and women who would not rate a footnote in its pages.

J Stewart Cameron
Clinical Science Laboratories



Guy's Hospital Dental Society-Clinical day

Clinical day on 6 March this year took on a new format which must have found favour with the weather gods if no-one else. Memories of Clinical Days past have so often included likening the Colonnade to a wind tunnel with true March winds and frequently somewhat early April showers.

Proceedings started in the Tower Lecture Theatre at 9.30 am with Professor Frank Ashley, Dean of the Dental School, introducing the Twelfth W E Herbert Memorial Lecture. This was given by Professor Bernard Smith who took the title, 'Will Conservative Dental Surgery soon be obsolete?'

Professor Smith started his presentation by noting that he was the first W E Herbert Memorial Lecturer who had not either been taught by or worked with Professor Herbert. He was however able to establish his credentials by relating the story of his own qualification examination, LDS, at which Professor Herbert was an examiner. Continuing in his humorous, Professor Smith identified three threats to Conservative Dental Surgery, epidemiologists, the General Dental Council and dental educationalists.

Each of these threats was examined in detail and evidence was produced to show that there is little doubt in Professor Smith's mind that conservative dental surgery is quite safe for the foreseeable future. The capacity audience were invited to join a vote of thanks by the Sub-Dean of the Dental School, Mr Laurence Usiskin which was given with great enthusiasm.

During the morning, demonstrations and posters were in view on Floors 21, 22 and 23. For the first time Alumni were invited to take part in these displays and four presentations were made by dentists not currently working for Guy's. Coffee and refreshments were available on both Floors 21 and 22, enabling visitors to continue their tour with coffee in hand.

Also included in the displays were student projects from Phantom Head Courses entered for the AHR Rowe Prize. Another new prize awarded this year was for the staff and alumni presentations. The winners were Dr David Brown and Mr Dennis Bailey with 'The Light and Shade of it' in which different lighting conditions were shown to have different effects on the apparent shade of denture teeth and a selection of restorative materials. Runner-up was Mr Peter Yerbury with his displays illustrating 'The functionally generated path technique'. The AHR Rowe Prize winner was Miss Jacquetta Dring with a presentation of the work from her initial phantom head course.

Throughout the morning many Trade Stands were also displaying and demonstrating their latest equipment and materials.

The formal proceedings concluded with the traditional 'Cases you have sent' lecture. With a capacity audience in the Tower Lecture Theatre, Mr Pat O'Driscoll related a large number of fascinating cases which he had seen. These illustrated a broad spectrum of problems ranging from spontaneous temperomandibular joint dislocations to malignancy presenting as apical infection on an upper central incisor.

Professor Ashley proposed the vote of thanks and reminded the visitors that a Cheese and Wine Lunch was available in

the Robens Suite. During the afternoon, the televisions in the Tower Lecture Theatre were set to show the 5-Nations Rugby international matches, thus allowing those with too great a distance to travel home the opportunity to see the games.

The changes to the layout of the Clinical Day arrangements were designed by Laurence Usiskin and his tremendous enthusiasm and hard work together with that of a large band of student helpers ensured that all 400-odd participants had an enjoyable time.

In the evening of Clinical Day, the Dental Dinner was held (this year in the Robens Suite for the first time) with Miss Meg Skelly wearing the Presidential Badge of Office.

After an excellent meal and the Loyal Toast, Mr Stephen Rear, Dean of the new Faculty of General Dental Practitioners at the Royal College of Surgeons proposed the toast to UMDS. The reply was given by Professor Ashley who summarised the activities of the Dental School during the past 12 months.

Guy's Hospital Dental Society was the title of the toast proposed by Professor Tony Adams, from the Department of Anaesthetics at UMDS. Miss Skelly replied on behalf of the Society with mention that she was only the second lady president in its 99 year history.

The final speech was a report on the activities of the Society given by the Secretary, Mr Greg Davies.

Organisation for the Dinner was expertly carried out by Mr Guy Palmer who must be congratulated on all his hard work.

Paul N Sheppard

What nurses do

How can nurses save this hospital £100,000? I recently came across an interesting example cited in a new magazine entitled 'Healthcare Management'. This is the sort of magazine where medical journalists, some of them trained doctors, write in a rather popular style, for a fee considerably greater than mine for writing here. As I don't get paidanything for writing here, that isn't difficult!

Some of these medical journalists have made enough of a living out of this practice to enable them to retire from medical practice altogether. Dr. Vernon Coleman is in this latter category, and has become known to a wide public through his contributions to tabloid newspapers. It is a pity he used his position to advise readers not to vaccinate their children against whooping cough. But to return to my subject - 'how can nurses save this hospi-

tal £100,000?' Well, apparently just by using their eyes! Jenny Bryan wrote in 'Healthcare Management' of how Professor Chantler quoted the above saying could be made if both medical and nursing staff routinely held urine samples up to the light: if they were clear and dipstick negative, there was little need to send a specimen to the laboratory. And if this practice was widespread, the total mentioned would be saved at Guy's; but imagine how much this sum would amount to if adopted nationwide. Even without Professor Chantler's advise it has long been the practice in Genito-urinary medicine clinics to check if urine is crystal clear and dipstick negative. Only those samples lacking in this counts are sent to the laboratory. So, seemingly simple tasks which even nurses are capable of carrying out, can save quite a lot of money.

It also seems that nurses are almost in a re-learning situation, if my own experience is anything to go by. The South-East Thames Region's most recent newsletter on nursing practice sites some examples of how nurses can save money and doctor's time. Amongst other measures suggested are - venesection and male catheterization.

Many years ago when I was a student nurse, being male I was thought to be one of the few members of staff available to perform male catheterization. Consequently, being a low-rise hospital, unlike our Tower, but with scattered buildings, I often found myself astride my bicycle, night or day, racing from one end of the institution to the other to insert another catheter into some unfortunate male patient. Male nurses were in short supply!

I write of the patient being unfortunate guardedly, as my arrival and successful catheterization, was often the cause of his being necessitated my task.

The extension of the nurses role, if such it is, has much to do with the economics of healthcare. If staff, of whatever grade category, can be trained understandingly to carry out certain tasks, there is often a possibility that this can relieve more senior, and higher paid, professionals. Needless to say, it is not sufficient to train people, unless they have some understanding of what they are doing, how it should be properly conducted, what may go wrong, how to minimise the latter chance, but also to know what to do if something does fail in the process. Nurses ceased some tasks in the past, which with their own accountability they may be expected to resume. This is a good thing, as nurses are very capable, and also get more job satisfaction if they are allowed to carry out any task at which they feel competent and comfortable. Legal restraints meant some forfeit of these practices in the past, but now that nurses have improved training, and the opportunity of wider post-registration experience and education, there is no reason why the position should be subject to petty limits.

Nurses represent the major wage expense in the health service, so the proper utilization of our skills is important. Some, less skilled parts of the job are, and will increasingly be, fulfilled by staff with a less exhaustive training. Getting the balance right, and ensuring that the right mix of staff is available, will mean that what nurses can do, they will do!

Denis Cobell.

1993 Men's UH Basketball Tournament

This year's tournament was held at the less than auspicious Seymour Leisure Centre. In total eight teams participated in this one day event. Two groups where set up so that each team had a total of three games lasting a total of twenty minutes. UMDS faced their first match against Royal Free, which started quite tentatively, with the usual missed shots and unnecessary fouls. However, the team managed to get its act together and eventually won. Bart's were our next opponents and again we managed to scrape through, the match being decided on a last minute free throw. After a three hour break we faced St. Mary's in a physical match which they unfortunately won quite comfortably, after a lethargic performance by us. Despite having won two of our three matches we were unfortunately knocked out due to the lack of baskets. However, we had an enjoyable day put together by the Medical Sickness Society.

This year we have played quite a few matches and have been quite successful despite the obvious lack of resources. Our training ground is the ULU gym which though is cheap is not the size of a proper basketball court which is essential for practice. However as we do not receive much funding from the student's union, it is the perfect venue. The plans for the coming year is to set up a first ever inter-hospital basketball league so that we can play at a more competitive level and produce a higher level of commitment to the game.

The Basketball club needs a President who can give us some guidance and support. Please get in touch with us through the Boland House pigeon holes.

V Varma
P Zolfaghari

Cricket: 2nd XI

The start of the 1993 cricket season was not without turmoil for the new 2nd XI, being left in the lurch without a captain. Thrown in at the deep end, Andy 'Pitt Pony' Williams bonded together a motley crew of volunteers, largely made up of 2nd year medics, with the odd 1st and 3rd year thrown in for good measure. We headed, with spirit, for the first game of the season against St George's.

Since we had been so hastily assembled and were as far as cricket goes, an unknown entity, nobody really held out much hope for the match. However, upon reaching Cobham, and finding George's as pleasant and scruffy a bunch of lads as one might find in any college bar, our competitive streak showed. In a somewhat farcical game we mopped up their batsmen, hit the required runs and won in plenty of time to reach the Bumps.

The next fixture at Mary's proved more of a challenge, and with our top six batsmen collapsing, it looked as though we could be returning home earlier than planned. However Pankaj 'Smith' Sharma at number eight saved the innings with a 'storming' 61 not out, to leave us with a very defendable 130 off 30 overs. Mary's found their earlier attitude of complacency hard to shake and launched a rather late attempt at recovery. We meanwhile were settling nicely

into our stride, learning as we went along, revealing talents prior to unknown and going into the next match against Imperial unbeaten.

Imperial were an entirely different kettle of fish. All in white and looking very serious they harboured some true 'giants ' amongst their ranks. The tallest of these, all six foot, eight inches of him, made up the brunt of the pace attack. With a run up the distance of a boundary and bowling at us from what appeared to be the sky, many of the batsmen wanted to go in lower than usual, fearing for their lives (and manhood).

Imperial batted first, led in by a Mr Trisomy. After 15 overs of being hit around the ground, it looked as if our time was up. We began to play in a rather disheartened manner, but then Sajay Varma made the vital breakthrough, catching and bowling Trisomy. Hungry for more wickets, having tasted triumph in the face of adversity we gave it our all and there began an Imperial collapse of several lightening run outs and tremendous catches. It was a true team effort, with Mark 'Ramparkash' Gins firing at the stumps aided by Sam Rajaratnam, and John 'Sturgeon' Davies at the wicket. As Andy 'Pitt Pony' Williams was away fencing a number of the team assumed captaincy, eventually falling to the shortest of us, Faisal 'dig in boys!' Khan to undertake this tallest of orders. We bowled Imperial out for 109 runs and at three runs an over we anticipated a victory. We assembled a capable, not brash, batting order and strode on forward. Despite some unusual bouncers from the Imperial pace men we kept our heads. A fast contribution of 20 runs from Flanjay set the scene, as our batsmen came and went. Sanjay remained steadfast and scored an unbeaten 50 not out guiding the team to a glorious and memorable victory with five wickets in hand. It had been our toughest game to date. A real team effort, played in the good-humoured way that marked all our matches.

Three victories in a row and a full set of fixtures are definite indications for a memorable season for the 2nd XI. An unruly mob turned into a world class team—well a slight exaggeration perhaps but we're still unbeaten.

Sanjay Varma

Spirochaetes Hockey Tour, Paignton 1993

The Spirochaetes undertook their annual hockey tour with the unique spirit and enthusiasm which has become their hallmark over the years. The squad was strengthened this year by the amalgamation with another Guy's hockey team, the 71st Lancets. The Lancets were formed in 1977 by recently qualified Guy's graduates who made was for a new and more virulent clone of treponemes. Over recent years the Spirochaetes have been drawn largely from the ranks of the professions rather than from the student body itself and some of the members have hung up their boots, and so it was timely for these two clubs to merge.

Spiros v Guys 1st XI

The Spiros assembled in March to play against Guy's 1st XI (perhaps it's called UMDS XI these days). In a well contested game the hospital achieved a narrow victory but the Spiros were able to flex

their rather fibrotic musculature and ready themselves for the rigours of tour.

The tour

The Hockey Festival was declared open in it's customary fashion by the Lord Mayor of Torbay at Clennon Valley and the Spirochaetes bullied off against the Cleevillains with the Festival President and Chairman in attendance. In a fast and open game our opponents took an early lead. Following this goal the Spiros applied unrelenting pressure and after a weak clearance from the Cleevillains line our strong-wristed left winger flicked the ball into the net. After much celebration the game resumed and the Spiros exerted control for long periods scoring two more goals, one a short corner by Whelan. In the final tem minutes our opponents came back strongly and scored a controversial goal that looked more like a overhead double-handed tennis smash.We were relieved to hear the final whistle. We lunched in a Cider Bar in Newton Abbott to the extent that our captain had some difficulty picking a side for the afternoon game. We played the Chieftains on a poor quality grass pitch in Dawlish. I had predicted a heavy defeat but we lurched to a draw cheered on initially by intoxicated supporters whose conscious level fell as the afternoon wore on. One member went AWOL and missed the van home. Some time later he started walking back to Paignton and when, ten miles later, he reached Exeter he realised he had been walking in the wrong direction. The Spiros indeed, are not renowned for sympathy:

'But Wait a bit,' a Spiro said,
A pint pot in his fist,
'For some of us are on the floor,
And all of us are p.....'
'No hurry,' said the President,
'You really won't be missed.'

Saturday morning had arrived and the Spirochaetes were one of the unbeaten sides. This was unprecedented. We were drawn against a team from a London Hospital which I believe has re-located at Balham. This team has done well in recent years but 1993 was to be their Pearl Harbour. Their dress was more suited to an operating theatre, their faces were painted with the colours of St George and their attitude was frankly lacking gravidity. The Spiros demonstrated their surgical skills with hugh victory of ten goals to one. We retired to the London Inn to savour the success and the ale. We were joined by Greaves, Quick and Zaheer although sadly they were not all in a fit condition to play courtesy of British Rail.

We drove to Totnes in the afternoon. In drenching rain the bus and Quick become engulfed in a wall of mud. Consequently we were caught slightly off guard in the first minute of the match and conceded a very early goal. The Spiros regained their composure and played a fine, if rather ill-tempered game, dominating for long periods but failing to score. Our unbeaten record was shattered, but not our hopes of the Bill Stickles Trophy. After such an overwhelming victory against St. George's we were leading contenders for this award (briefly).

The Spirochaetes attended the Lord Mayor's cocktail party and received a special presentation for long and charismatic service to the festival. Tony Gardner collected the presentation with histrionics more reminiscent of those who work in broadcasting.

A poor game Sunday in a deluge was followed by an excellent display of skill, determination and fortitude on the astro

at Dawlish against the Falcons. Our opponents scored an early goal but the Spiros pressed hard and their efforts were well rewarded when Pitman deflected a powerful cross from the left wing. It was a great goal and fully justified his appointment as Spirochaetes captain in 1994. We were unlucky to concede a goal in the dying moments of the game but honoured to have taken part.

Team: Blowers, Jones, Quick, Whelan, Peebles, Pitman, Pocock (Capt), Masani, Russell, Atherton, Griffin, Scott, Smith, Fewster, Greaves, Cole.

David Cole

UMDS Rugby: 1st XV

UMDS Rugby 1st XV v Lille Medical Students. Sunday 21st March 1993. Won 54-5.

In March of 1992, an intrepid band of warriors sallied forth from the forth from the gates of UMDS, met and defeated France's finest in a skirmish on the outskirts of Lille, and carried away with them the spoils of war in the form of two precious chalices with the finest ales.

The French King, angry at this affront to his Gallic pride, solemnly vowed to avenge himself. In the spring of the following year, the storms of winter having passed, he assembled a great army of noblemen in the port of Calais; their design: 'England, and Revenge!'

In the Borough of Lambeth there arose a leader to meet this challenge, Richard of Oval. Unfortunately, he was banned, and so there arose a replacement leader who had been safely tucked up in bed with his horlicks at the time of the incident.

The yeomanry of England were campaigning in many different places as the French advanced on Cobham, but by mobilising his reserves of 'Old Faithfuls' the English leader was finally able to meet the French Force, by arrangement, on Sunday 21st March at an ungodly hour.

The battle, or 'match' in the language of the time, proved to be very one-sided. The French side contained few regulars, and it was not long before the UMDS men were thrusting deep into the French half. In the words of a spectator, 'leur team n'aimait pas le sight d'un gros forward charging at them. Le fullback etait aussi tres vulnerable sous le high ball. Ainsi les UMDS ont supplied les backs avec un bon supply de good ball, qui seemed de temps en temps to be capable de scoring at will (pas du tout en charactere).' Tries came regularly throughout both halves,. and were it not for the presence of our regular kicker the score would have been in the high seventies. By the end, The French had been well and truly routed, 54-5, our finest win of the year by far.

The diplomats then stepped in, giving the precious chalices filled with the finest ale beause the footy boys had lost! Nevertheless, it was a real success of a weekend and cemented the fledging relationship between our two institutions, etc. I suppose that the rugby team will face a backlash of some sort in France next year, but then again, that's what I thought this year.

Team: A Haiatt, M Tutton, M Lewis, E Barrio, A Bates, K Smith, G Lawton, D McAuley, A O'Brien, M Henderson, R Perry, P Goodyear, J Thallon (Capt), J Spencer, C Marshall. S Challacombe (Referee).

James Thallon

The UMDS team

The Lille team

Rugby: 4th XV

Guy's 4th XV v Bromley A. Won 32-18. On the 20 February 1993 Guy's 4th XV played Bromley A. With the wind and a slight slope in their favour, Guy's made the most of their advantage in the first half to give themselves a lead of fourteen points, a gap which Bromley couldn't close in the second half.

After some early pressure Guy's were rewarded with a try by Goodwin. Bromley came back at Guy's straight from the restart and were rewarded with a penalty. Guy's then scored the try of the match with good lineout ball being moved quickly down the line to winger Lewis to score in the corner, Lloyd's conversion made it 12-3.Again Bromley scored from the restart to make it 12-8 but this was their last score of the half. Both Lloyd and Lewis scored before the break to give us a good chance of holding out against the slope and the wind.Things looked even better when Ekeowa scored from a counter-attack by Guy's after Bromley had been camped in their half for a long period. Some Guy's complacency allowed the Bromley skipper to score twice; once after the Ekeowa try and once after Davies' try in the last minutes. However, the gap was still fourteen points and Guy's won deservedly especially as they played the entire match with fourteen men.

Team: Hostert, Morgen, Howells, Blunder (Capt), Eddy, Larns, Sharp, Davies, Lloyd, Ekeowa, Osborn, Goodwin, Lewis, Probert.

M. Blunder

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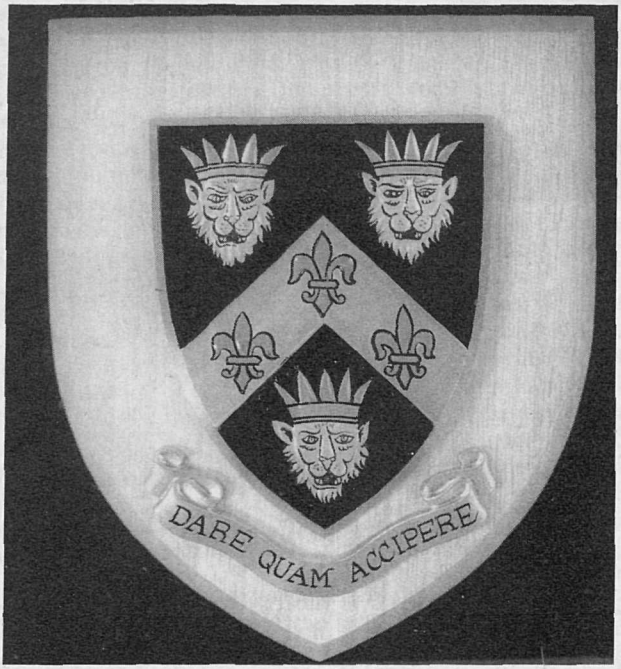

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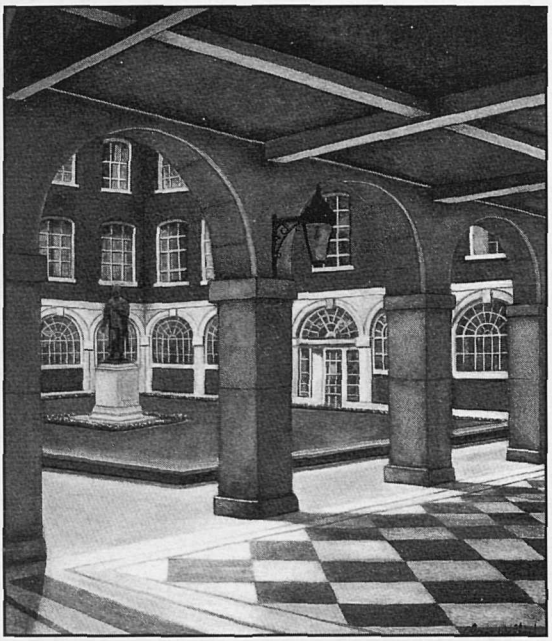

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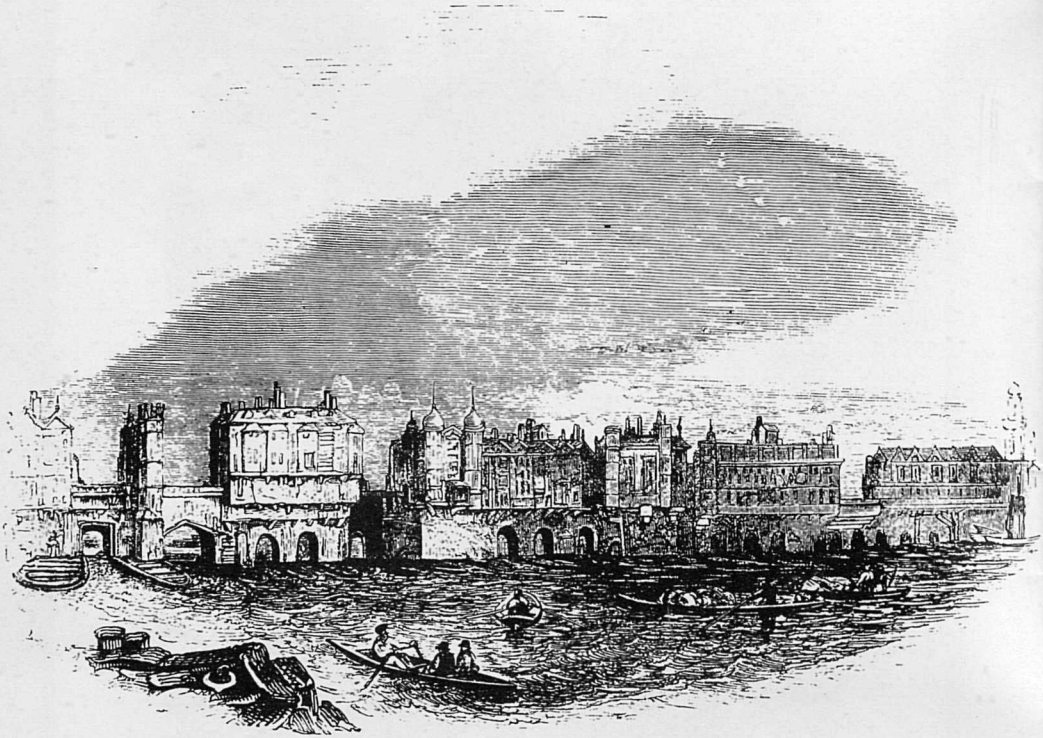

London Bridge just before the Houses were pulled down in 1760.

CONTENTS

134 **Passim**

135 **Letters**—A Guy's First

137 **News**—Appointments, AZT, SWGHS

141 **Public Health Project**—Not reporting needlesticks

145 **Obs & Gobs**—A 'Mini-Elective' in Turkey

149 **Gazette Interview**—Miss Meena Agrawal

153 **Articles & Experiences**—Further notes by J H Pitt-Payne

160 **Reviews**—Textbook of MCQs

160 **Obituaries**—Sir John Prideaux

162 **Dental Notes**—New scholarship

162 **Nursing Notes**—Nurse practitioners

164 **Clubs Union News**—Drama, Holistics, T'ai Chi

166 **Sport**—Boat, Football, Hockey, Netball and Rugby

176 **Classifieds and Announcements**

UMDS Guy's
-9 JUN 1993
Wills Library

Guy's Gazette

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Passim

I feel as if I should begin my first passim with an explanation for the May issue appearing in June. A succession of 'beginners mistakes', aided and abetted by the fax machine losing documents account for the delay. I apologise and hope to 'do better'.

On 11 May 1993 the Trust Board of Guy's and St Thomas's released the work programme for the strategic review that will guide the merger process. It is divided into four phases; the first, to end May 1993, is concerned with assessing the extent and effect of changes in efficiency, clinical practice, hospital organisation etc. It will also establish data on the running costs and analyse the market position of the Trust and assess the requirements of UMDS. Phase II, to end June, is concerned with specifying physical requirements including those of the University and the options for A&E provision. Site options will be considered in phase III, to be presented to the Trust Board on 5 August. Phase IV, to end September 1993 is the refinement and finalising of proposals and presentation of recommendations to the Secretary of State.

It is needless to say that the decisions of the Trust Board will have far-reaching implications on the hospitals themselves and the provision of healthcare in London generally. They will also greatly affect UMDS and the proposed merger with Kings. It is to be hoped that the present phase of 'requirement assessment' will see the standard of Clinical teaching being maintained and present problems such as the large size of some of the firms, being addressed. There is also, as ever, a need for improvement of student on-campus facilities. Hopefully some concrete improvement in these will result from the mergers.

St Thomas Guy ?

Dear Sir,
I have been interested by the recent correspondence about 'St Thomas Guy'.

Bearing in mind that 'saint' as used in the New Testament, refers to any christian, rather than somebody canonised by the Roman Catholic Church, we may well be perfectly entitled to refer to 'St' Thomas Guy.

I think, therefore, that St Thomas Guy's Hospital would be an admirable name for a united institution.

Yours faithfully,

Dr R G HENDERSON
Consultant Radiologist

The Fogarty Catheter

Dear Sir,
During preparation of a short article on the contributions of Guy's men in the field of organ transplantation, I recently wrote to Professor Folkert Belzer, Chairman of the Department of Surgery at the University of Wisconsin-Madison Medical School. Although not strictly a 'Guy's man' (in that he did not study medicine at Guy's), Dr Belzer spent a year at Guy's as a senior lecturer in Surgery in the mid-60's. He has subsequently made major contributions to organ transplantation, particularly in the area of organ preservation.

In his reply to me, he gave further information on his time at Guy's, which I believe would be of interest to readers of the Gazette, and which is of some historical interest with regard to the development of surgery in the United Kingdom. From his letter:

I was at Guy's as a senior lecturer from December 1964 to December 1965. My appointment was under Professor Hendley Atkins, a pioneer, of course, in the treatment of breast cancer. His trial of lumpectomy versus radical mastectomy, the first real study in that area. I was not involved in transplantation during this time, and my clinical work at Guy's was split between general surgery (including a large number of breast cases) and vascular surgery.

As Tom Fogarty and I were surgical residents together in Oregon, I was actually the first to introduce the Fogarty catheter to England. The Fogarty Catheter had just been manufactured commercially, and Tom Fogarty was kind enough to give me three catheters, one of each size. I vividly remember the first two cases I did using the Fogarty catheter.

The first was a fairly young woman in another hospital connected with Guy's. This lady had severe mitral stenosis and had thrown a saddle embolus to her aorta. At the time we saw her she was in extremis and, under local anaesthesia, I did bilateral cut downs on the femoral arteries and removed the embolus. She underwent a successful mitral valvotomy a week later and did well.

The second case was a patient on the medical service at Guy's who had thrown an embolus to his leg. He had been on the medical service for about five or six days with extreme rest pain when the physicians consulted us. We took him to the operating room, removed the embolus and walked him back to the medical service a day later. As you can imagine the word spread rather quickly, and I was fortunate from then on to do most of the vascular surgery, not only on Professor

Atkin's service, but also on the so-called private patients.

I think back to my year at Guy's as one of the most enjoyable times of my life. As my appointment was for only a year, I was obviously not competing for any jobs at Guy's and perhaps therefore had a great relationship with all the surgeons at the institution. Because of my fond memories of my year in England, we have instituted here at the University of Wisconsin, a great relationship with an NHS hospital in Gloucester, England. We send one of our chief residents, after completion of training in medicine, for a year to England. This has proved a great success.'

And so it seems that the important development of removal of thrombus with the Forgarty catheter was first introduced into England at Guy's Hospital.

Yours faithfully,

D K C COOPER
Director of Research and Education
Oklahoma Transplantation Institute
Baptist Medical Centre
Oklahoma City
USA

Classifieds and Announcements

The *Gazette* is pleased to publish classified advertisements. These are charged at the rate of 10 pence per word—money with order please. It is helpful if you can include a contact telephone number in case of any queries.

Announcements of births, deaths and changes of address will be published free of charge.

Please ensure that these items reach the *Gazette* office four weeks prior to publication.

New appointments

The Principal will recommend the following appointments to the Council of Governors, at its next meeting.

Professor R J Hay, the Mary Dunhill Professor of Cutaneous Medicine, will become Dean for External Affairs. Dr D Brown, senior lecturer and head of the Department of Dental Materials Science, will become Sub-Dean for External Affairs.

Dr R B Scott, clinical director of the Lewisham NHS Trust will be replacing Dr P J as Sub-Dean for Lewisham, to maintain links with UMDS, and to look after teaching and research activities on that site.

Two Clinical Sub-Deans will be appointed to assist the Clinical Dean with curriculum implementation. Dr N T Bateman, Honorary Senior Lecturer in the Division of Medicine, will be the Clinical Sub-Dean on the St Thomas' campus. Dr P J Rees, senior lecturer in the Division of Medicine will be the Clinical Sub-Dean on the Guy's campus.

New Joint Trust

Virginia Bottomley, Secretary of State for Health, has approved the establishment of the Guy's and St Thomas' Hospital Trust, which became fully operational on 1 April 1993. At the same time the existing Guy's and Lewisham NHS Trust Board was dissolved and the Lewisham Hospital NHS Trust established.

The Guy's and St Thomas' Hospital Trust is the largest in the UK, with an annual income of approximately £240 million. The Trust aims to provide high standards of patient care, to develop links with community care, and to provide high quality research and teaching.

Lord Hayhoe, Chairman of the new trust, remarked in Connections (the new staff newspaper), ' I am determined to ensure that the Trust builds a reputation for excellence based on the strengths of both hospitals. If this goal is to be achieved it will require the support and commitment of all staff.'

Tim Matthews, as mentioned in April Gazette, is the Chief Executive of the Trust. Other appointments include: John Pelly, Finance Director (formerly Finance Director of St Thomas'), Professor Michael Maisey (Professor of Radiological Sciences, UMDS and co-chairman of the Joint clinical Directors Group of Guy's and St Thomas') as Medical Director, a post jointly held with Mr Tony Young (Consultant Surgeon and Director of Surgery, St Thomas's). Wilma MacPherson (formerly Director of Nursing, Guy's and Lewisham Trust) is Nursing Director and Karen Caines (previously General Manager, Guy's) has been appointed as Project Director.

Virginia Bottomley has asked the new trust to submit proposals, within six months, for consolidating clinical services, and to decide whether an accident and emergency department is needed on both sites.

Reviews of six specialist services are to be established across London. The services to be reviewed are: cardiac services, renal services, cancer care, plastic surgery, neuroservices and specialist children's services. In view of this, specialists at both Guy's and St Thomas' are working to ensure that the new trust makes a significant contribution in the future pattern of these services in London.

Meanwhile progress in the merger of UMDS and King's College depends on the decisions to be made by the joint trust, such as whether Guy's or St Thomas' will be the main hospital site.

Research news

In addition to performing well in the recent assessment of research facilities undertaken by the Universities Funding Council (*Gazette News*, February 1993), UMDS continue to attract more research grants than ever. As of 31 January, total grant income for the financial year ending April 1993 was 27 percent higher than for the previous year.

Memorial fund for Laurence Davies

Laurence Davies, a first-year student at UMDS, died on Saturday 13 February, aged 19. His family asked for contributions in his memory to go to a fund for helping those with diabetes to study medicine. Laurence was a diabetic and at the time of his death was being considered by the British Diabetic Association for an award to assist him during his medical studies.

The Hermon Whittaker Fund is administered by the British Diabetic Association and provides bursaries for students with diabetes who are reading medicine. Contributions to this fund as a tribute to the memory of Laurence Davies should be sent to Helen Brook, School Office, Guy's Campus, (cheques to UMDS).

BMA President

Professor D C Morrell, Wolfson Professor of General Practice, will become the next President of the British Medical Association.

Macmillan Nurse Appeal

David Gower, England's former cricket captain, is to become patron of the 'Macmillan Mile Challenge', a fundraising event in aid of the Macmillan Nurse Appeal, helping people with cancer.

Following the success of last year's challenge, the event is to be repeated between May 8 and 16. For every mile that is covered by participants £1 is donated to the Macmillan Nurse Appeal. The appeal was launched in September 1991, to raise £20 million to fund a further 260, mainly hospital-based, Macmillan cancer care nurses.

For further information and sponsorship forms, contact Lynne Hawkins on 071-867 9256.

International congress on hepatitis B as an occupational hazard

A major international congress, organised by the Viral Hepatitis Prevention Board (VHPB) has recognised hepatitis B as, 'the most important occupational infectious disease'.The

congress took place in Vienna during March. A computerised survey of delegates showed that two-thirds agreeded with this view, whilst a third of the 250 delegates were unsure. A recent study carried out on behalf of the VHPB, estimates that about 300 healthcare workers die each year from acute fulminant hepatitis B, or the chronic effects of liver cirrhosis and primary liver cancer.

The congress also heard that European Community institutions are addressing hepatitis B as an occupational health issue, for the first time. The European Parliament has just recommended that employers offer free vaccinations to workers at risk. A new EC directive obliges employers to protect workers against hazards posed by biological agents, through the use of safer working systems and where an effective vaccine exists, as it does for hepatitis B vaccination. Member states will have until November 1993 to implement the directive by national legislation.

AZT - A beneficial drug?

The effectiveness of zidovudine, (azidothymidine, AZT), in delaying the onset of AIDS in asymptomatic HIV positive individuals has been called into question, following the preliminary analysis of the Concorde trial. This is a multi-centre double-blind, placebo-controlled study, set up in 1988, to establish whether asymptomatic HIV-infecteds would benefit from starting zidovudine at randomisation, instead of deferring treatment until the onset of symptomatic disease.

The trial did not demonstrate any significant benefit from the immediate use of zidovudine compared with deferred therapy in asymptomatic individuals, in terms of survival or disease prognosis. These findings, reported in a letter to The Lancet, also cast doubt on the value of CD4 cell counts in monitoring the effectiveness of antiviral therapy and disease progression in HIV-infected individuals. Immediate use of zidovudine at the beginning of the trial had a significant effect in limiting the change in CD4 count in individuals but no significant effect in limiting disease progression, or indeed survival.

Previous trials have shown zidvudine to be beneficial in delaying clinical progression to AIDS, however this is after a relatively short follow-up time. This recent trial did not show this delay over a longer follow-up period.

Further analysis of the Concorde trial is taking place and patients are continuing to be followed-up.

Reference:

- Aboulker J P and Swart A M. Preliminary analysis of the Concorde trial. The Lancet 1993, 341, 889-890.

South Wales Guy's Hospital Society

The 42nd annual dinner of the society was held at the Park Hotel, Cardiff, on the 6 February 1993, under the Presidency of Mr I Rocker. The guest of honour was Mr E D Morris, recently retired from Guy's.

An excellent crowd, over 90 attended, good food, speeches and after-dinner entertainment combined to make a thoroughly enjoyable evening. The next dinner, for Guy's men and women and their guests, will be held on 15 January 1994.

Graham Davies

From left to right: Mr Christopher Lewis, Immediate Past President, Mr Ed Morris, Guest of Honour, Mr I Rocker, President and Mr Graham Davies, Honorary Secretary.

Public Health Project '93

Needlestick Injuries and why we don't report

During the first clinical year every medical student studies public health medicine for five weeks. In this time we have lectures, tutorials and also work together in small groups on clinical projects. Within the five weeks the chosen project has to be fully researched and then prepared for presentation to half of the year and the PMH tutors. This, as well as the impending PMH exam, does not leave much time for research and data collection but it introduces those who have not done a Bsc to project work.

The aim

Our group was approached by the sister of UMDS, Occupational Health Department, St Thomas's, to investigate needlestick injury reporting amongst medical students, a needlestick being defined as an injury breaking through the skin when taking blood, during surgery, or mucocutaneous contact splashes or injuries. We were also asked to examine general knowledge about needlesticks, hep B and the services that Occupational Health have to offer.

The group decided that the easiest way to collect information was through an anonymous questionaire, targeted at students in their third year and an equivalent number in the fourth year. This allowed us to compare those who had received a series of lectures in occupational health in their GP quartile, with the third years who had not.

Collecting the data

In the third year we gave out 81 questionaries and received back 66, a response rate of 81.5%. This high response return was perhaps because of the number of other questionaires, requiring peer attention, being circulated in the third year. Of these responders there were 8 (12.1%) needlestick injuries of 1 or more (75% 1 injury, 25 % 2-3 injuries) and 58 no injuries, in the given period of the past six months.

We, however were not so fortunate with the fourth year. The majority of the year were on peripherals, dispersed far and wide. We managed to target 29 fourth years, with 24 questionaires being returned. Of these there were 8 (33.3%) needlestick injuries (75% 1 injury, 25 % 2-3 injuries). 16 (66.7%) had not experienced an injury in the same six month period.

Needlestick injuries most commonly occurred during taking blood or using a scapel during surgery. The small numbers involved in the study meant any results and conclusions drawn had to be treated with a degree of caution. However we hoped that we would get an idea of the degree of knowledge that students have regarding needlesticks and also some pointers as to their behaviours regarding reporting.

Not reporting the injury

Of the 8 third years who had had a needlestick injury 6 did not report the injury, their main reasons being: reporting was too time consuming, not believing there was any personal risk from the injury, concern about the effects of reporting on their career, not realising reporting an injury is a standard procedure. Both of the students who did report their injury to a doctor were told not to bother pursuing the matter any further.

Of the fourth years 6 (75%) did not report the injury, giving reasons of, too time consuming, career and HIV complications, not believing there was any personal risk from the injury, embarrassment. As the fourth years had received their occupational health lectures it was good to note that 'did not realise reporting is a standard procedure' was not a reason given for non-reporting.

Of the 2 who did report their injury, 1 was told not to pursue the matter any further and the other actually managed to report the incident to occupational health and fill an accident form.

The next question, 'would you report an injury', was directed at those who had not experienced a needlestick injury.

In the third year 72.4% believed they would and 27.6% thought they would not, giving same reasons of, too time consuming, concern about effects on career, not realising reporting is standard and also not believing anything could be done about the injury and risks.

Of the fourth years 81.3% said they would report an injury and 18.7% said they would not as it was too time consuming and they would be concerned about effects on their career. Again the fourth years, as a group, appeared to know reporting was a standard procedure.

Services on offer

The final part of our questionaire asked about the services that occupational health have to offer. The following table shows those relating to needlesticks and the percentage of third and fouth years that answered correctly:

Due to the small numbers involved in the study, we were not able to show any statistical difference between the third years (who had not had the OH

Question: Occupational health can...	Percentage with correct answer	
	3rd year students	*4th year students*
Identify hepB/hep C/HIV status of patient.	61.9	69.6
measure hepB antibody level of the student and give hep B antibodies and/ or a booster dose of vaccine if the antibody levels are low.	77.8	100.0
Counsel the student if the blood is thought to be contaminated with HIV and store the blood for testing	58.7	65.2
Provide possible zidovudine treatment if large doses of if large doses of HIV infected blood have been received (question asked before The Lancet article).	25.4	39.0
Document the injury for medico-legal compensation reasons.	52.4	52.2

series of lectures) and the fourth years (who had). However from the results we obtained it is apparent that few of the medical students questioned were aware of the correct procedures for reporting needlestick injuries, or of the services that occupational health can offer.

As reported in *Gazette news* this issue, viral hepatitis is regarded as 'the most important infective occupational health disease.' The Viral Hepatitis Prevention Board regards a fast response as vital whenever a needlestick injury has occurred, delays making post-exposure prophylaxis less effective. The board also recommends that there should be no restrictions routinely placed on healthcare workers who have been identified by blood test as being chronically infected carriers. It acknowledges that these workers need to be advised individually and may need to modify their work practises, any restrictions being arrived at by agreement between the employer and employee.

It is apparant from our study that medical students are unsure of the importance of needlesticks and also what they should do, as standard, if one occurs. There also is concern about the consequences of reporting needlestick injuries. Though the OH lectures given to all fourth years appear to inform them to a degree, there is still a feeling that reporting is too time consuming and uncertainity about possible adverse effects on careers. Given that third years are exposed to the possibility of needlesticks before the OH lectures perhaps information could be sent out to all medical and dental students about the occupational health service. Jo, the Sister of UMDS, (Occupational Health

STH) will be writing an article for a future issue of the *Gazette* about the dangers of needlesticks, the correct procedure to follow, and why, and also the role of the Occupational Health department and what it has to offer to students.

The people involved in this project were group B8 (STH) under the guidance of Raymond Jankowski and Dr Madon.

J. Waterman

Turkey

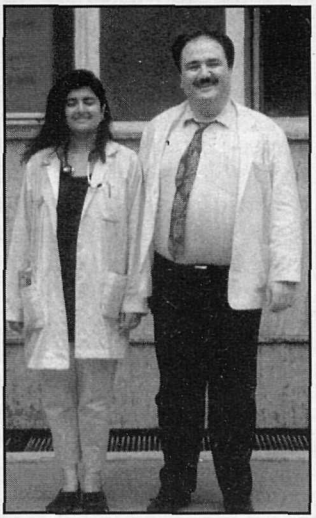
My mini-elective in Obs and Gobs

'Fire! Fire! Everybody get out of the Hospital!' Part of the theatre block was ablaze and this triggered pandemonium throughout the building. It was my first day, 9.20 am, barely twenty minutes into the Gynaecology Clinic, Haciettepe University Hospital, Ankara.The Registrar put down his speculum and, taking off his gloves, he said,

'Never in the history of this city ma'am, has there been a fire in this hospital..... What a great coincidence.'

I spent my summer vacation of the 3rd year in Turkey on what can best be described as a mini-elective in Obstetrics and Gynaecology. It was actually conveniently placed in the middle of my O & G Quartile. The opportunity arose via EMSA (European Medical Students Association) who provided me with contacts in Haciettepe University Hospital, Ankara.

I was taken under the wing of Dr Yilmanz Gebi, a Registrar, with whom I attended Gynaecology clinics, theatre and antenatal clinics. He was nicknamed 'Stan Laurel' by the interns (final year medical students) because he was to put it politely, extremely well rounded.He, like all the staff was extremely polite and always called me ma'am. He was an excellent teacher, allowing me to examine nearly all the patients, insert speculums (up to fifteen in one session) and take smears. The department used ordinary hair spray to set the smears. Dr Gebi also carried out an unusual ritual of smelling every speculum after insertion, informing me that different pathogens have characteristic odours. He would always offer me a sniff but for some reason I would always decline.



The Author and 'Stan Laurel'

Half of the Turkish medical students are taught in English so there were no language barriers with doctors and medical students but sign lan-

guage and a few phrases were my only means of communication with nurses and patients. Indeed this did become a little frustrating when I could not clerk patients or understand consultations but doctors and interns would always give a brief resume of each patient.

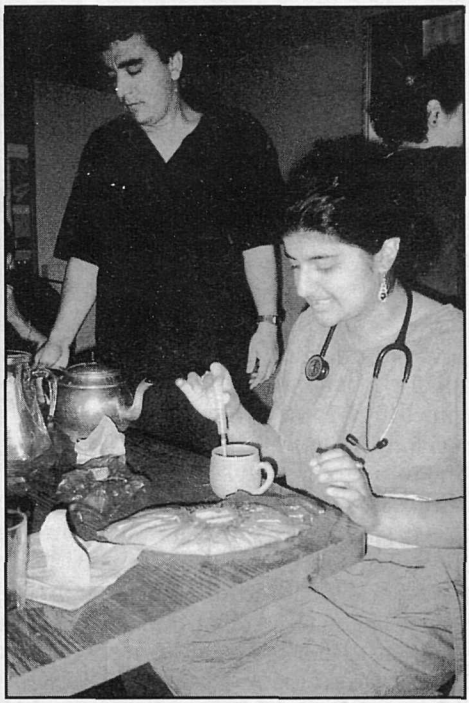
Haciettepe served not only local town area but the rural areas on outskirts of Ankara. Women particularly from these rural areas were often late in seeking medical advice (partly because of the lack of primary care available) and often presented with gross 'textbook' symptoms, extremely useful for a novice such as myself. There were also some unusual cases including a patient who had presented to the clinic that morning with a chronic history of abdominal pain, vaginal discharge, dysuria and 'near death'. She was quite hysterical and unfortunately incomprehensible. There was a communication barrier because she was Bangladeshi and only spoke pigeon Turkish (and no English). Pelvic examination revealed a foreign body, a surgical swab left behind in the vagina, from an operation on her bladder 3 months earlier.

I do not know what I was expecting but I was surprised at how modern the hospital was both in architecture (there was an uncanny resemblance to St Thomas's) and in management. However consultations were occasionally unusual; it was amazing just how 'open house' they could be. Other colleagues, interns, consultants and even hospital management would enter the room to consult Dr Gebi as he examined a patient in the lithotomy position. However Turkey is 99% Muslim, all women whom I saw were extremely modest and very conscious of male staff to the point that several patients refused, quite voiciferously, to be examined unless the male internes left the room. None of the patients ever demanded that I do the same. I think it was because I was,like them female and also (after they had made specific enquiries) because I had origins from Pakistan. Indeed Pakistan turned out to be the magic word in Turkey; the great warmth, gifts, attention and even at one point a military escort by the Turkish Army, that I received whereever I went was based on the fact that Pakistan had been an important ally in the Turk-Cypriot war.

Although Dr Gebi was an O & G man, every so often the out-patient clinic would be dotted with General Medicine or Surgery. He was held in such high regard by the locals that the Gynae. clinics were often complemented by medical or surgical patients, or relatives of Gynae patients brandishing X-Rays, blood results etc seeking his opinion.

A sweltering and bumpy bus journey to another part of Ankara, took me to the third largest maternity hospital in the world (apparantly India has the largest followed closely by Brazil). At one time this establishment boasted 120 deliveries a day. I was looking forward to my time on this labour ward

because of the prospect of being able to both see and do much.Three weeks at St Thomas's had been fruitless. I had only been able to witness one normal delivery let alone deliver. Approaching the labour ward the corridors were full of the screams and wails of mothers in the process of being. I soon learned that although the hospital looked quite modern it served the lowest socio-economic members of the local community. Funds were limited. Disposable gloves were recycled, being washed, sterilised and left to dry on corridor window sills. The tea-room did not have many utensils. Capped syringes were used for spoons and theatre hats for carrying sugar and biscuits. Analgesia was not used for the first and second stages of labour (no pethidine, entonox, or epidurals). One SHO had heard of the epidural but had never seen one. Only lignocaine was administered for the repair of episiotomies. Admittedly at this point I did not feel like staying. I had been weakened by an unsavoury donar kebab I had eaten the night before but the staff were once again very keen to show me around and encouraged as much 'hands on' as possible.

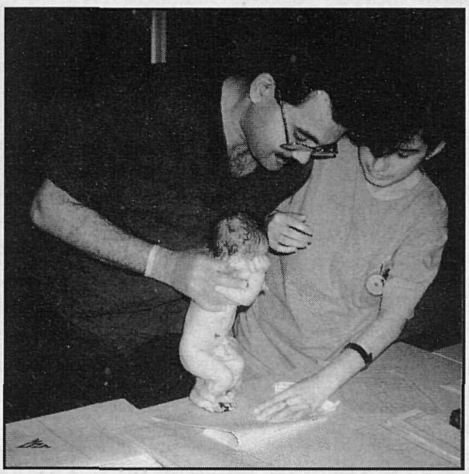


Capped syringes were used for spoons.

I had arrived in the 'rush hour'; all fourteen delivery cubicles were engaged by mums-to-be in the process of delivery. One woman just could not wait for a vacancy and ended up delivering in the waiting-room next door, watched by nine other mums-to-be who were themselves close to delivery. Episiotomies allowed the staff to cope with the overload. Indeed if a mother failed to deliver quickly enough she was given the 'big E'. During the rush hour I was allowed to witness as many deliveries and episiotomies (including those with blunt blades) as I wished and even given the opportunity to repair episiotomies. Once the rush was over I was then allowed to deliver babies (as many as seventeen over a few days) under the supervision of the SHO or the

midwife. 'Okun'—push in Turkish, proved to be the meat and veg of my grasp of the Turkish language, aside from the usual nicities such as 'hello', 'thank-you' and 'where are the toilets please?'

A tradition in Turkish hospitals is footprinting as part of the usual labeling post-partum. Footprints of neonates were stamped in patient notes. The newborn were then put into community cots, with as many as six other babies, while the SHO ran off to repair the episiotomy. It was at this point that it dawned on me why I had seen so many episiotomy scars in Hacieppte.



A Tradition in Turkish hospitals is footprinting.

My time in Ankara was an invaluable source of experience both inside and outside Medicine. Everyone was so keen to teach and to allow as much hands on as possible, although my inablity to clerk patients, purely because of my inability to speak Turkish, was a minor drawback. I went in July which was a good time of the year as most of the medical students were on vacation. Hospital food (passable) and accommodation (unisex dormatories,no hot water,hole-in-the-ground-toilets) were almost free but one needed a sense of adventure to cope. A few important points for those of you perhaps considering visiting Turkey; everything in Ankara including donar kebabs, turkish delight, Raki, bellydancers, silver and Turkish baths is extremely cheap, all policemen carry (what I believe to be) Kalashnikov rifles, even traffic wardens carry guns. It appeared to be very effective—the crime rate in Turkey is very low. The presence of Kemal Ataturk, 'Father of the Turks', the pre-war dictator who led the country at the end of the Ottoman Empire into Western Civilisation is always felt. He died aged 42, from alcoholic cirrhosis, addicted to the national drink, Raki (as well as women). Everything appears to be named after him.

Turkey is a great place to go for an elective. It has an excellent climate with lots to see and do in spare time as well as plenty to do in the hospital. Turkey is truly a combination of East and West—I would recommend it to anyone.

Naheed L Khan
4th Year student

Miss Meena Agrawal

Consultant Paediatric Surgeon

Miss Meena Agrawal was appointed Consultant Paediatric to Guy's Hospital and the Childrens' Hospital, Lewisham, in 1989. She has become one of the most prominent paediatric surgeons in the south-east of England. In this interview I attempted to find out more about her work, interests, background and views on health and political issues.

Miss Agrawal's primary work is that of a general paediatric surgeon for Guy's and Lewisham, a catchment area including patients from south-east London and surrounding districts. She also holds 'out-reach' clinics in Dartford and Ashford, covering most of the south east region. Besides general paediatric surgery, her special interests are neonatal surgery and paediatric urology. Miss Agrawal also maintains an active interest in clinical research, being currently interested in developing minimally invasive surgical techniques for children. 'These techniques are already well-established in adult surgery, for example cholecystectomy, and I believe that in selected cases we could use these techniques in children.' Indeed she has recently been to Australia, for a course in this developing field. She is also involved in the Foetal Medicine unit at Guy's and participates in counselling parents of babies with surgical problems diagnosed antenatally.

I asked Miss Agrawal for her views on the current changes in the NHS, particulary the looming merger between Guy's and St Thomas's. She agreed that, 'The merger is probably a necessity and is inevitable in the current political and financial circumstances.' She was concerned, however, about the significant decrease in in-patient beds available. Miss Agrawal also feels that improving primary care may not necessarily reduce the need for secondary referral and in-patient care, especially for problems requiring surgical intervention. 'Some specialities may be perhaps adversely affected by the emphasis on results, cost-cutting, and rapid turnover, for example geriatrics and mental health, if primary and community care facilities are not adequately developed before hospital beds are decreased as a result of the forthcoming proposed changes.'

Miss Agrawal also has an active role in teaching medical students, I asked how she thought teaching would be affected by the UMDS-Kings merger. ' This is difficult to forecast but it would hopefully consolidate teaching for

medical students in south-east London. Overall student intake maybe reduced in London by the proposed Tomlinson teaching hospitals closure or merger. I do know however that those in charge of the student's education are determined that the standard of teaching will not suffer.'

Miss Meena Agrawal

I went on to ask Miss Agrawal about her personal background. Born in India, she spent most of her early life in Bombay. It was there that she had her schooling and later graduated from Grant Medical College. She was the first doctor in her family and I asked her when she decided she wanted to do surgery. 'I suppose I had always wanted to be a surgeon but I was discouraged from very early on. It was not thought appropriate for a female as many saw it as an exclusive male domain. However I was determined and not easily discouraged by the sceptics.'

Miss Agrawal obtained her Masters degree in General Surgery and was a registrar in India. She came to England and here obtained her FRCS from the London and Edinburgh colleges. 'Part of my registrar training in the UK involved doing some paediatric surgery. I really enjoyed it and although my original intention had been to do adult general surgery, I was encouraged to specialise in paediatric surgery.' She worked as Senior Registrar and later as an Acting Consultant in Paediatric Surgery at the Hospital for Sick Children, Great Ormond Street, (GOS), and Queen Mary's Hospital for Children. She subsequently obtained her accreditation as a specialist in paediatric surgery. In the UK as well she found, contrary to her expectations, it was almost as difficult benign a female in a surgical speciality. Being a foreigner did not help either, but she went on to say that people too easily use such things as excuses

for not really persevering. 'If your're absolutely determined to achieve something, and you believe in your ability and you are prepared to achieve something and you are prepared to make sacrifices, then you will eventually achieve your aim.' She has no regrets about not having brought up a family of her own, although she feels there should be more provisions and encouragement for female health professionals who wish to have a family whilst pursuing a demanding, competitive career.

I asked Miss Agrawal about her other interests, of which she has several, and admit I was surprised to discover she is an accomplished mountain climber. 'I have, from a young age been interested in sport and out-door activities. I became interested in mountaineering while at medical school. It was at about that time mountaineering was being popularised as a sport for ladies in India.'She has represented her school and college in hockey and athletics and used to be in the Girl Guides and National Cadet Corps. From these she gravitated almost naturally into mountaineering. She has in fact been a medical officer on several international ladies' expeditions to the Himalayan peaks. She has trekked and climbed in many mountain ranges. These have included the Alps (including Mont Blanc), the Polish Tatia mountains, High Atlas mountains in Morocco, Africa (Kilimanjanu), Alaska and South America. She has climbed extensively in the various ranges in the Indian Himalayas, including the Kanakonams. She was Medical Officer on an expedition to Mount Everest in Nepal a few years ago. During her various expeditions she has encountered and had to treat many and varied medical problems amongst the villagers en-route as well as problems specific to mountaineering and high altitude. She has had some varied adventures and misadventures on her trips, some exciting and some sad but says she feels enriched by her experiences.

Some of the expeditions she has been involved in have been written about in mountaineering books and Miss Agrawal herself occasionally writes articles for mountaineering journals as well as medical journals. She is also a member of various mountaineering and climbing associations such as the Himalayan Club and the Alpine Club of Great Britain. She is a fellow of the Royal Geographic Society of Great Britain.

In conclusion I asked if she had any further ambitions to fulfil. She replied in her typical modest manner, 'One always has some ambitions I am happy with the way things have turned out and look forward to the challenges of the new NHS.'

S A Khan

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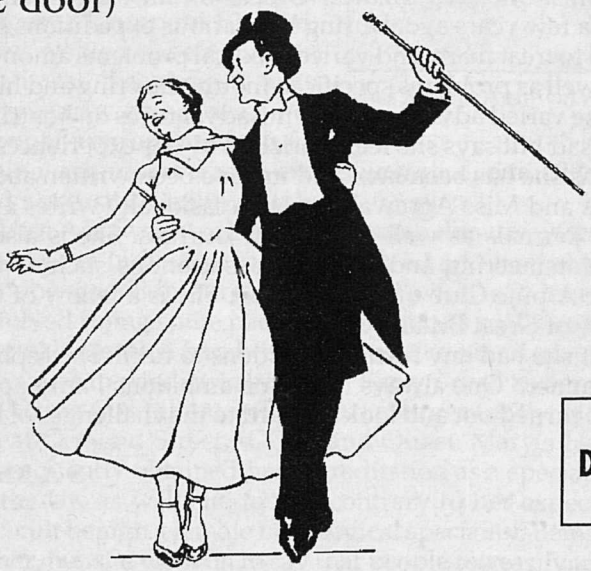

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GBG'93

Articles and Experiences

By J H Pitt-Payne

As I'm sure readers will notice the usual 'recollection' articles by Dr Pitt-Payne have been replaced by what I, for want of a better term, have described as 'articles and experiences'. They share the same inimitable style and continue to be the bane of proof reading, as one so frequently forced to laugh that the purpose of what one is doing is quite forgotton.

Early Days

My first recollections go back a long way away to those days when I was still in my pram. They used to park me in the back garden, fresh air deemed to be just the thing to make a small baby grow fit and well. I didn't walk until I was two, and my landmarks were all somewhat retarded. This was attributed to all manner of things, and I often wondered what had happened to my Mantoux test which was found to be so strongly positive. The garden was a dangerous place to be for small boys, and when I was but four years old, I accidently pulled the stone bird-bath down on top of my head— thus necessitating my first X-ray at Bromley Hospital. I was a constant trial to my elder brother, and our bedrooms were subsequently divided by a partition. As a child, I indulged in all manner of bad behaviour which included, breath-holding attacks, temper tantrums, and head-banging with such success that I learnt how to move my cot from one side of the nursery to the other.There was much knowledge to be acquired, learning all too quickly the disadvantages of medical parents—and how their practised use of the soap suppository might overcome all resistance. These fearful items are worthy of a mention, for they were fashioned from a large block of that ghastly green soap, and, despite my dear mother's insistence that the finished item was rounded and suppository shape, I persist in my belief that they were actually rectangular with sharp edges. It is the only case that I can cite where the square peg actually fitted into the round hole. To be fair, she always applied vaseline to this freshly manufactured article.

At the age of seven I had tormented my brother, Michael long enough, and eventually he gave chase. It was a very good chase—right round the garden—and then I stopped suddenly and he ran into me and I was knocked to the

ground. The next thing I knew it was dark and I was in my bedroom. It was my first memory of retrograde amnesia, an eminently forgettable experience, and the second time my parents rang Bill Atkinson (Mr W J Atkinson MD MS FRCS, Neurosurgeon and Barrister-at-Law) who always gave excellent advice which involved doing nothing—and leaving me alone. I'm sure if we left more of our patients alone, they would be ever so much better for it.

The makings of a doctor

I have been hyperactive and what with the whooping cough and measles to negotiate plus the inevitable catarrhal ailments I was frequently in bed. There is nothing quite like a sickly childhood for the makings of a doctor. With too much time for play and not enough for work, I was able to develop alone without the constraints of the educational process—which came later. I had eight volumes of *Newness Encyclopedia* to read and their medical section always fascinated me even at an early age. Most of the explanations as to why the body worked were shown as little men who opened and shut doors, thus letting food, bile, pancreatic juices, or whatever, either through, or out. The things that made me the most curious were, needless to say, never explained. Nor were the facts of life.

A practical mind—for pranks

I was given radio sets to take apart and it was here that my love of wire came into being. It was not long before I had learnt how to dismantle a transformer and unravel the hundreds of yards of wire contained therein. Another piece of kit that was to prove useful was the transformer I had for my 'Trix Twin' train outfit. I found that if I wound the thin copper wire round a pin, I could make a small filament, which, when coupled to the terminals of the transformer, would glow bright red briefly before melting. So was born the 'Pitt-Payne Balloon Detonator' and it was my poor, long-suffering Aunty Hilda who got the benefit of my discovery. Sellotape bound the freshly made filament to the balloon which was then placed under my aunt's chair—all in advance of her post-prandial nap. The tiny wires then trailed out under the door, and, when she was esconsed in her chair, asleep with her mouth open, I would detonate the balloon, pulling the wires swiftly under the door so the evidence vanished before it could be detected. So, there'd be a loud bang, followed by a cry of protest from the freshly-awakened, aged relative—and then the usual litany about her poor nerves. By this time I was well out of the way. I also made electric motors out of bits of cork, paper clips, and a couple of magnets. My father encouraged my interest in all this kind of thing. But he was never there when I blew up Aunty Hilda.

Plastic gloves had yet to arrive on the scene, but there was the humble finger-stall. I had no idea as to their real purpose but my father would blow them up so they made a small balloon and then shove them up the chimney when there was a good fire glowing in the crate. We would all rush outside to watch it coming out of the chimney. It was all great fun and there wasn't a *Nintendo GameBoy* in sight.

The visiting doctors

From time to time, Guy's consultants came down to Bromley to see my father's patients. One of the most distinguished was Dr Christopher Hardwick MA MD FRCP, Consultant Physician to Guy's Hospital. He was a compact man in a three-piece suit, so well cut that it may well have been a second skin. To a young person, he was the personification of 'braininess'. If a consultant ever came to our house it was time to get on parade and he was always offered a cup of tea. No one drank coffee at Guy's Hospital in 1965. We even had Lord Horder along one day and my father had arranged for the fee to be paid in cash. The crackling white fivers were handed to the ennobled doctor who broke into a broad smile and said, 'Why thank you, my boy.' to my father.

Dr. Hardwick was known as 'The Wick' at Guy's and he and Professor Trounce had a firm together. I knew none of this when I was little. What actually happened was that our Corgi, Rusty, had raided the incinerator where he had found an unconsumed watch-spring pessary which had done its time in holding up some aged prolapse. Rubber watch-spring pessaries were just the ticket in those days. Plastic had yet to make its mark in the strange world of gynaecology. The dog came in, wagging its tail, with this item in his mouth—and laid it at the feet of 'The Wick'. My mother, so the story goes, says she could have gone through the floor. (With an offspring like me, it would have meant a trap-door in every room, of course). Those of you who remember Dr Hardwick will realise what an incongruous item a stale rubber watch-spring pessary was to lay at his feet. I remember him with his half-moon tortoise-shell spectacles heading up Ward Rounds and felt that here was one of those medical intellectuals in a rarefied world quite removed from anything I could have envisaged.

Early experiences and embarrassments

My own experience in the medical field were rather more ordinary and the times when I wished the earth could have opened beneath my feet were well in hand. I began in General Practice in late 1971 and soon my father suggested that I see a young patient, who, he said, wished to go on the pill. I duly ushered a glamorous seventeen year old into my office, and then commenced with

what I was assured would be my opening gambit, 'I understand you want to go on the pill?' I ventured. A look of puzzlement crossed her pulchritudinous features.

'No. I have got a sore throat.'

'Ah...' I replied. For a moment I was stumped. My mouth hung open as though my tongue were a piece of fly paper. 'Ah..' I repeated. Then I blushed. That was the worst of being a young man—and unmarried too. 'I'm so sorry...' I burbled, 'I thought you wanted to ah-um...' I trailed off. Twenty years on and that woman is now nearly forty and we still laugh about that meeting which neither of us forgot. I am pleased to say that she has two children and we remained the best of friends.

I always admired the ability of my colleagues to remain firm in the face of adversity. One of the hardest hurdles for the young medical student to face is the reality of another's humanity. Such dilemmas I faced when I was early on in my training and found myself clerking in a 27 year old secretary who had overdosed on aspirin to the point where her ears had begun to ring and she became frightened enough to come to Casualty. I must have shown great concern because I know I got a good history and then I announced that I would examine her. I drew the curtains round the bed, on Stephen Ward it was, and when I turned round she had drawn her nightie up to her chin so that she was completely exposed. At the tender age of 19, this was something that had never happened to me before and the colour on my face said it all as I ventured to cover her up. 'I'm afraid you are way ahead of me', I confessed.

'How old are you?' This was just the sort of question I dreaded but after a truthful reply I was treated with such consideration that I began to wonder just who the patient was. I learnt early on just how vulnerable the young doctor could be when faced with the reality of a wounded psyche, and it was experiences such at these which made me the more determined to do better with such characters who were crying out for attention.

General hysteria

Hysteria in General Practice has happened from time to time and it should always be taken seriously, or at least I feel the doctor should play his shots with a straight bat. Even so, these occasions may give rise to a smile as they are looked back upon. There was an eighteen year old girl to whom I was called after she had collapsed in the doorway of her mother's sitting-room. I got there as soon as I could and she was duly sprawled on the floor and apparently unconscious. I took her pulse and then stood up. 'It's no good', I began, 'I'll never be able to lift her up. I think I may have to drag her by her feet, but then

that'll make her dress ride up.' I pondered all this out loud with her mother as I went through the conscious action of scratching my head. I walked out of the sitting-room into the kitchen, indicating as I did so that this was what I'd be doing next. Then I heard a groan and my patient stirred. She came into 'consciousness' all too quickly, thus sparing herself the ignominy of being dragged from one room to another across some rather cold parquet flooring.

On another occasion, and another floor, another patient lay prostrate—only this time the smell of ethanol was unmistakable. So when I stood up and announced, 'She's drunk!' I was somewhat surprised at the voice which came from below me and said,

'No I'm not!'

Then there was the woman, who, on the eve of her wedding suddenly went blind. No amaurosis fugax here, I fear, and nor was there any evidence to suggest a homonymous hemianopia. There was a blindness which stated that everything below the horizontal when glancing ahead had gone. I had opted for a spot of auto-suggestion and the blindness increased and she hyperventilated. I restored her sight by intravenous expedient of diazepam 10mg injected very slowly, all the while suggesting that she would see again, and that her sight would be restored to her as she relaxed. This is exactly what happened and everyone was very impressed. Eventually, I had the honour to be asked to be the Godfather of her first child.

And then there was Emily. I was called somewhat urgently to her home as she was having a panic attack. She was agoraphobic and claustrophobic and in due course she would need lots and lots of psychotherapy. However, I was to inexperienced to know how to set about the myriad of problems which assailed her and I tried to improvise using hypnosis as a means of helping her to relax. I had not bargained for the role her mother would play in the proceedings, nor did I have any understanding of her mother's antipathy towards such a course of action. Undaunted, and ignorant, I asked Emily to concentrate on the tip of my cheap biro where she would fix her gaze whilst I invited her to relax. Things were underway when there was a knock on the door and her mother came in, having left the room when I had suggested hypnosis. 'Would you like a cup of tea, doctor?' I was asked. I said,

'Yes, that would be very nice.' and resumed my attempts at hypnosis. Some moments passed and then there was another knock at the door.

'Do you take sugar, doctor?'I nodded and began to feel that I was being nobbled, but I persisted. I did not have to wait too long before there was another knock at the door, and this time there was a veritable rattling of cups and saucers as the whole shebang came in on a trolley and it became clear that afternoon tea had been imposed on the whole occasion. I threw in the towel

at this moment and never again was I to attempt anything of that kind with Emily. Her mother had proved what a problem she was and there was little point in going any further with hypnosis.

Sorting it out

Out here in the suburbs we don't get too much excitement and anything that is out of ordinary tends to cause a bit of a stir. Always it's a case of someone saying, 'Somebody ought to do something.' Such characters are usually of the most inert type and seem to have spent their entire lives delegating everything they see which is out of order to a mythical mass of carers, fixers, and the ubiquitous GP who seems to be the first in the queue for all the mucky jobs. A classic of this kind was a gentleman, who, on leaving the local golf club, would tend to relieve himself in everyone's front garden on the way home. As he was rarely out of his cups as it was, he remained blissfully unaware of what he was doing, obeying the commands of nature whenever they visited him. In the course of time I received what amounted to a deputation but I made a mistake in my calculations in that a smile started spreading across my face. 'If you didn't look out of your front windows', I reasoned, 'you'd never see him'. This line of argument didn't wash with the local populace.

'Something has got to be done!' they argued. I agreed with vigorous head-nodding movements, trying all the while to make some amends for finding the whole situation rather funny. I had to bow to convention as it seems we all have to. Strange how intolerant we tend to be in matters appertaining to the natural bodily functions.

Take the post nasal drips as an example. This is a tedious complaint in that it tends to go on happening in spite of what we try to do for it. Kleenex have been relying on it for years and we can divide the nation into those that sniff and those who blow. As in all these cases, what may be a trickle to some is a flood to others, but whatever the volume of catarrh the tolerance of it seems to be directly proportional to the psychological mood of the patient in question. Their voices suddenly become fogged by the something that has slipped past the epiglottis and landed on the vocal cords. Or it may be something that has been wafted upwards by those columnar ciliated epithelial cells that are a part of my explanatory repertoire. In all the years I have tried to explain away catarrh, I doubt me there ever was anyone who knew what I meant by 'columnar' or 'ciliated'. There's a saying that if you meet a Scotsman at the border and ask him the way to Edinburgh, by the time he's finished clearing his throat, you could have made the journey there. This intolerance of ourselves belies on intolerance of others, and the ethmoid sinus continues to do its stuff blissfully unaware of the nuisance it causes.

Who's to blame?

We are for ever trying to find the scapegoat. Recently, there was a very successful total hip joint replacement performed on one of my patients. A text-book procedure, though I say it myself, she went home and was doing very well until the fifth week when she noted a swelling posterior to the scar. It turned out to be a stitch abscess and duly discharged as the wound rehealed by secondary intention. It was a case of some good 'laudable' pus and then the Eusol Solution and packing. In due course, I was asked this question, 'Whose fault was it that this happened, doctor?' I was nonplussed. It's not a matter of who to blame when something goes wrong, but it was her body which had decided to react to the stitch in question and I would have had to say that it was her fault and not the fault of the surgeon who did the operation.

J H Pitt-Payne

Medicine

Textbook of Medicine MCQs. Souhami and Moxham et al.

This companion book to the worthy (and weighty!) 'Souhami and Moxham' is broadly aimed at Final Year students and MRCP candidates. It contains 300 stem questions, each of six parts, and so in numerical terms represents good value. I showed the book to fellow students, approaching Finals with trepidation and the general verdict was favourable; the questions are varied, and follows the parent book in format of subjects, the content often is wide-ranging. Some topics such as clinical pharmacology, are only give cursory attention, but generally the core medical subjects, such as cardiology, are better. However, explanations to the answers are not always given, and there is no cross-referencing to the parent text. Hopefully the publishers will change this in future editions. Nevertheless, the depth of knowledge required for the questions is well-pitched. To conclude, it is a book broad in scope, that is successful in self-testing the core subjects, and provides some piece of mind to nervous final year students.

R A Patey

Gazette Obituary

Sir John Francis Prideaux OBE, DL

All who have been associated with St Thomas's Hospital, UMDS and the West Lambeth Health District for most of the past thirty years will have been touched in some way by Sir John, and will be sad to learn that he died, peacefully, on 7 January 1993, after a long illness, bravely borne. Sir John was eighty-one on 30 December.

The 1963-64 Annual Report of St Thomas's Hospital marked the retirement of the Honourable Sir Arthur Howard, KBE, who had served the Hospital with distinction from 1943-1964 as Treasurer and Chairman. The Report emphasised that, from its inception in 1552, the office of Treasurer had been the cornerstone of the administration. John Prideaux, Esq, OBE, inherited the mantle on 1 February 1964. He was a merchant banker, and then Deputy Chairman of the Westminster Bank, later to become Chairman of the National Westminster Bank from 1971-77, and Chairman of a number of other City financial institutions. He was knighted in the 1974 New Years Honours.

Some people at St Thomas's wondered what on earth a banker could possibly know about running a hospital. Mr Prideaux agreed that he knew nothing,

and set about the task with the characteristic commitment that had been his hallmark ever since, even up to days before his death, in bringing people together to consider the future, after Tomlinson.

Sir John was the last Treasurer of St Thomas's Hospital. The Board of Governors was dissolved on 31 March 1974, and Sir John was appointed the first Chairman of the newly created Special Trustees for St Thomas's Hospital. Sir John was also appointed Deputy Chairman of the new Lambeth, Lewisham and Southwark AHA, along with two former Governors, the late Lady Seebohm and Dr H J Anderson (who also became Special Trustees, along with the then Sir Max Rayne, and the late Mr F Kemmis Betty). In 1979, during a particularly difficult period in the management of Lambeth, Southwark and Lewisham AHA, Sir John became one of the ministerially appointed Commissioners for St Thomas's Hospital—a particularly good move for St Thomas's in that, once again, management decisions were taken locally.

As Treasurer, Sir John and the management team, led by Mr Bryan McSwiney, Clerk of the Governors, built on the foundations of the post-war redevelopment laid by Sir Arthur Howard and Mr Pelham Borley, successfully negotiating with the Ministry of Health to secure the funding for the present North Wing, Lambeth Wing and Gassiot House complex. This building complex, which holds his bust on the North Wing staircase, is an obvious testimony, but a less well known one which required almost equal energy and tenacity, is the pedestrian crossing outside Accident and Emergency.

Sir John ,as Treasurer, had served the Hospital with distinction, and was to continue doing so as Chairman of the Special Trustees until his retirement in 1988, when he was succeeded by Mr Peter Lumsden.

Retirement did not diminish his interest in St Thomas's, the Medical School and the Health District in any way. He continued to influence events behind the scenes, and was an enthusiastic President of the Friends of St Thomas's, the St Thomas's Hospital Veterans' Association, the Iris Fund and REFRESH.

One of Sir John's many interesting facets of style was that of speech, of which Peter Lumsden reminded him at his farewell dinner in 1988, referring to him as the master of the unfinished sentence.

Over the centuries, St Thomas's has bred many famous sons, and the Hospital and Medical School now mourn one of them.

Sidney Smith Sanderson scholarship

The Dental School is a beneficiary in the Will of the late Sidney Smith Sanderson, who was a dental student at Guy's in the early 1920's. He directed that a one third share of the estate, which amounts to £50,000, be used for the benefit of dental students at Guy's Hospital. In order that the value of the bequest is maintained the School policy is not to spend in excess of 5% of the capital each year. It has therefore been agreed to establish a Scholarship of £500 per annum in the mane of Sidney Smith Sanderson, which will be awarded in competition to help fund a student elective. The remaining £2,000 wil be used to assist students who are suffering financial hardship.

Sidney Smith Sanderson was born in 1891, entered the school in 1920 and qualified in 1923. It is interesting to note form his record that he was, 'allowed to present himself for Part II in November 1923 in view of his war service'.

We have been unable to trace any member of Mr Smith Sanderson's family but, who knows, possibly someone reading this will be able to put us in touch so that we might let them know how grateful we are and how we propose to use this money. Our records indicate that he came from Hull, initially from 35 Dryden Street, Holderness Road and then subsequently from 291 Beverley Road. We would certainly be grateful for any information.

Professor F P Ashley
Dean

Nursing Notes

Nurse practitioners

Nurses at Guy's have now taken on the role of practitioner, and are carrying out a variety of tasks which were formally performed only by doctors. This does not mean they are just the 'handmaidens' which some folk thought they once were. But now that nurses are accountable for their own practice, they must ensure that they are better informed, trained and advised in order to protect themselves. Many of the tasks now carried out by these nurses are not entirely new to them. Indeed, in the not-so-distant past, nurses did, perhaps, sometimes unofficially give out drugs and carry out certain treatments which they have not done in more recent years. Nowadays, all practice is much more circumscribed, and it behoves each individual nurse to be aware of their accountability and the consequences which may follow if practice rules are breached.

Also of interest is the advent of a new reference book, undertaken by a group of

nurses and pharmacists at Guy's. 'Professional Nurse 1993 Nursing Drug Reference' (Mosby, price £12.00), which has just been launched at a pleasant party held in the Robens Suite. This book contains details of more that 700 generic drugs and over 2000 trade drugs. It contains comprehensive information on the pharmacology of individual drugs and the nursing care needed for patients who are prescribed these drugs. Unlike the other formularies—both local and national—this edition is specifically aimed at nurses and midwives. Each drug is described in a similar manner to the formularies, but there are nursing considerations. These are divided into assessment, administration, and evaluation, including notes for teaching a patient and family. This will be especially useful to nurses and midwives working in the community where patients or their families have control over the taking of drug treatment. This book will be invaluable to nurse practitioners who are responsible for some prescribing, and also for initiating further individual administration.

The intention is to improve the quality of care. Another area of interest, initiated by our own 'Directory of Nursing', is patient-centred care. Apart from our knowledge of drugs and their action, this is a more ambitious enterprise. It looks at the physical layout of the traditional ward and how patients are grouped. At present, this is according to speciality, but mixing disorders may be an advantage. Locating services nearer to the patient and employing multi-skilled staff are other aspects of patient centred care. Inevitably, the main improvement, both for patients and staff, and evaluating costs involved, is to ensure that the length of hospitalization is reduced to the minimumpossible.

The 'wholeness' of care for a patient is the ultimate aim; nurses can improve their care by acting as 'advocates' for patients, and increasing their knowledge of 'health promotion'. All in all, there are many burgeoning aspects of nursing care which will improve the way we look after our patients and extend our role into more interesting and fruitful fields.

Denis Cobell

United Hospitals Drama Club

This year's United Hospitals drama competition, the second of its kind, took place at Bart's Hospital on the evening of 15 March. The four contesting hospitals, St George's, The London, UMDS and Bart's themselves, were presented with a title 'Into the Light', and asked to design a 20 minute play around it. The results were interesting, to say the least, with the audience in each case being left bemused as to what connection each offering could remotely have with the title. In fact, St George's, the eventual winners, also managed to scoop the 'Most Tenuous Connection of All' award, having been forced to make one of their characters, looking embarrassed—as well he might—slip the title into one of his speeches.

Our own play, written by Guy Thwaites, was a rather surreal murder-mystery-suspense episode, concerning the brutal and callous murder of the parson Snagsworth (Will Dixon, featuring his pet sheep Ramsay, plenty of line-forgettage, and a Welsh accent which seems to have stuck fast ever since), by one of his ageing parishioners, via an arsenic-laced greengage and custard cupcake. This same murderess, played by Lorraine Frost (in fine thigh-slapping form after her triumph as Aladdin in the Christmas show), subsequently turned out to be having a frenzied and passionate affair with the parson's hoover, Mrs Vacsuck.

Mrs Rinkle, a 97-year old stroke victim, complete with all-too-realistic catheter, and Mrs Wobbleclump, played by Jane Neerkin, who had valiantly stuffed a couple of pillows up her dress for the sake of her art (without realising that they made her skirt ride up a bit too suggestively for a woman of Mrs Wobbleclump's mature years—not that the laaaads in the first few rows minded), played the supporting roles in the comedy. Well,we thought it was a comedy, but the only time the Bart's audience laughed was when Lorraine almost brought the scenery down when wheeling Mrs Vacsuck on stage.

As to the other contestants, well, the beer monsters who made up the cast from The London presented a bizarre Paraguayan Jail story. The Bart's entry was excellent, and presumably, the only reason they did not win was because it would look like a bit of a fix—still, that didn't stopped us last year.Finally, can I just say that there was a severe lack of supporters in evidence that night. In fact, it was positively shaming, next to the coachload of fans that George's and The London had brought along. Maybe next year?

Orna McGinn

Holistics Student Group

So what is Holistics? Well, let me first say a little about the BHMA Student group.

The group usually meets on the first Tuesday of each month, starting at 19:00 in the crypt of Maryleborne Church, Marylebone Rd, just east from Baker St Tube. There are also occasional day workshops, and retreats out of London for weekends. Any student interested in the group, or an individual topic, is welcome to join or just come along for the evening that interests them specifically. Most

members at present are students of a variety of healthcare professions, from various schools around London.

The group is very much self-run with members organising talks or demonstrations on topics that interest them. In the past these have ranged from hypnosis, acupuncture, and 'The Alexander technique', to art, music, and movement therapy, dealing with stress, breaking bad news, and a visit to the London Lighthouse. The workshops have included practical-based days on counselling skills, and massage.

More recently there was another very successful retreat away from London to a large farmhouse surrounded by woods and fields, away from the great rush of London life. The weekend was spent lounging in front of the log fire, digging the garden to pay for the use of the house, and members sharing their various thoughts, experiences and talents with each other.

Returning to the original question—I still haven't found an adequate phrase or definition of Holistics, but if you have an open and enquiring mind, and are interested in more than the purely pathological theories of disease and therapy, or if you just want an interesting evening in enjoyable company, then come along and find out for yourself. And bring some food to share at the end of the evening when we sit round chatting!

R Torok

T'ai Chi Chu'uan—the gentle martial art

T'ai Chi Ch'uan is an ancient and distinctive form of exercise as well as an effective self defence technique and a popular form of 'Alternative Medicine'.

As an exercise, T'ai Chi Chu'uan is designed to promote relaxation through the practise of body conditioning exercises. It employs flowing, rhythmic, deliberate movements with carefully prescribed stances and positions. These movements make up the 'forms' of T'ai Chi. Depending on the school, the number of exercise forms varies from twenty-four to one hundred and eight. The forms are named after the images created by their execution, such as 'white stork displays its wings'.

Although often described as the most cerebral of the Martial Arts, T'ai Chi forms are based on the concept that thought confuses action. The forms are ideally performed in a meditative state.

Despite its somewhat esoteric reputation, T'ai Chi can be usefully practised by everyone. T'ai Chi does not require any level of fitness— it is very often practised by people aged eighty and over. However, with continual practice, a high degree of fitness can be attained. Don't let any preconceptions of T'ai Chi or the Martial Arts deter you from taking part. This is the first time that T'ai Chi has been taught at UMDS. The club has no links to any 'Martial Arts Society' past or present.

Karl Finn is an experienced instructor in several Martial Arts as well as Yoga and Meditation. He practises a universal form which is accessible, easy and enojoyable to learn. Sessions will be at the Pavy Gym, Guy's Hospital on Thursday evenings at 8pm. There will be a charge of two pounds for students. Please come along if you are at all interested, as without your support, T'ai Chi will not be able to continue at UMDS.

Mubasher Sheikh

Guy's Hospital Boat Club

Women's Head of the River Race.
The 53rd Women's VII Head, on March 6, marked the end of the term's competitive rowing for most of members of the ladies' club. Following wins in both UH and UL head races, both novice and senior crews were eager to race against a wider field of opposition. Limited entries and second year exams meant the 2nd VIII and the fresher's B crew were unable to compete in the 4.5 mile race from Mortlake to Putney.

The 1st VIII completed their shopping just in time to make the start and, after a frantic beginning, the crew soon settled into the rhythm set by stroke. Vital seconds were saved by Mo's excellent coxing, taking us through to finish in a time of 22 minutes 31 seconds, a great improvement on last year's time and undoubtedly the VIII's best performance this season. The novice VIII, hampered by two last-minute substitutions, a shaky start and a first-minute pulled hamstring, were powered along the course, virtually single-handedly, by Jane Neerkin. Rob Huggart, experiencing the stress and strain of coxing his first ARA event, proved his worth by steering a faultless course throughout. The crew's eventual time was 23 minutes 50 seconds—the best result a Guy's 2nd crew has achieved in this event, and destroying all other hospital opposition.

Galway Tour, March 13th.
We hardly had time to recover from the Head of the River Race before leaving for Ireland on the first GHBC overseas tour, to compete in the famous Galway Head of the River Race.

After an exhausting 21 hour journey, broken only by a brief stop in Dublin, we arrived in Galway to find the town in a frenzy of excitement about Saturday's race—or was it the dance afterwards? Wandering through the town centre, with our eight blades searching for Galway's most eligible bachelor, Jerry McSweeney, we were spotted by a member of the Tribesmen Rowing Club who directed us to the boat house and within half an hour had drawn up a program of pre-race outings, coaching and land-training, supplemented by a high iron and protein diet of Guiness and oysters. However, we did find some time to relax and sample the Irish life-style; Dony's Irish roots surfaced in a folk music competition, and Julia surprised us with her talent for jigging.

Excitement in the town grew to near fever pitch by the day of the race—TV, radio and newspapers all contained lengthy reports which, to our excitement, all mentioned us. By Saturday morning, though, the situation at the boat house could only be described as chaotic. 200 boats (mostly incomplete) covered every inch of land from the water's edge to the cathedral steps. Things were looking black for our crew when 30 minutes before the start, our designated boat was still lacking seats, footplates and a rudder! Luckily, Tribesmen came to the rescue, finding us a replacement boat belonging to the Army, allowing us just enough time to row up to the start before the race began.

The pre-race training and the army warm-up paid off as we raced in some of the worst conditions I've ever known (following the morning's gale warning).

Mo's pre-race briefing also paid off, as she steered expertly between buoys, around hidden rocks, tucking into the bank to balance tide and wind. The adverse conditions had almost doubled the time we expected the race to take, but determination and a solid rhythm carried us through to victory, winning the club's first overseas prize, best overseas crew. However once the race and prize-giving were over, we were left in no doubt as to what everybody else considered the most important event of the day....

Louise Ward
Vice-Captain

Men's VIIs, Kingston Head of the River Race

A week after Bristol and fresh with the knowledge that our win had set a new class course record (albeit in near perfect conditions), the men's 1st VIII entered the Kingston Head. With the ladies flying the flag in Ireland and the men's 2nd VIII sitting exams, this traditional Guy's fixture was an ideal opportunity for the men's novices to venture off the Tideway for the first time entering both a squad VIII and IV in the event.

When the boat trailer arrived at Kingston, such was the enthusiasm to race that both 'Winalot' and 'The Sloth' were eagerly waiting to assemble the boats, adjustable spanners in ever-so-slightly clammy hands. With all the boats together in double quick time, there was an opportunity for a pre-race practice for all crews—a Guy's first in my recollection.

The practice was solid and confident and things looked good for the race to follow. This year, the usual arrangement of boating in strict reverse numerical order was replaced by a chaotic free for all with Guy's making absolutely the wrong decision to queue on a pontoon being used by the St George's novices. Maybe the sun got to us, standing for what seemed like hours waiting for George's to boat, but they did seem to be using the pontoon to build their boat from scratch.

Despite a hurried paddle to the start, which included a heated discussion between Stroke and 'Winalot' as to whether, and if so when, and if so where, and if so how, to overtake the Oxford lightweights, there was no chance of being able to start in the correct position. In fact, this year it appeared that very few crews were able to enjoy that privilege. This disorganization was however to cost us dearly.

As we turned into the start, Cox rightly called for firm pressure and the boat lifted out of the water spurred on by cheers from the novices waiting to race. Suddenly, the VIII began to steer violently toward the bank, Cox bravely ignoring the stream of instant advice from Stroke. Just as well since a crew from St Paul's School racing in front of us (but moving much more slowly) had ignored the rules and strayed into our path. Despite the evasive action a major blade clash was inevitable less than a minute into the race, with strokeside blades disappearing underneath the Pauline shell. Within a few seconds we were clear but the incident prevented the establishment of the ultra-smooth rhythm unveiled at Bristol. Nevertheless, the row over a longer course saw several crews overtaken and the power never let off for an instant.

When the results were announced, the crew was awarded 37th place out of very strong field of around two hundred and narrowly lost its class by only three seconds, which was the price of the blade

clash. However, disappointment soon turned to delight when we realised that we were the fastest hospital and had beaten major rivals, The London. The novices rowing over an unfamiliar course against competition which was almost without exception more experienced also acquitted themselves well both off (and on) the pontoons.

Jonathan Robin
Captain

UMDS Ladies' football

UMDS v Bristol. National Association of Medical Schools Cup. Won 6-0.
Finally the UMDS Ladies' football team have answered all those sceptics who dared to question our football abilities . Yes it's true, the Ladies' team, in our first season have walked away with a cup—anything the boys can do, we can do better.

The score in the final against Bristol was 6-0, but it could have been twice that. With several regular first team players missing and the 'Boss' (Sarah Brooks), playing her first full match after injury, it looked to be quite a task at the start of the final. But Sarah's promise of, 'No more fitness training if we win', proved to be inspirational.

The game was only 10 minutes old when Liz Selvandurai, with that incredible pace of hers, powered through the middle and finished with all the composure of a world-class player, 1-0. Lou Meredith proved to be a dymano in midfield, spraying balls around like she was John Barnes. She made it 2-0 when she floated a perfectly-weighted shot over the keeper's head, from the edge of the area.

When only two minutes from the restart Liz put the result beyond all doubt when she baffled the Bristol defenders with her quick feet and tight ball control, driving in her second and third goals. Score 4-0. Bristol were still reeling when Reena Kurian added to the goals with a strike from the narrowest of angles, through a crowd of players and past the poor stranded Bristol goalkeeper. Meanwhile our own goalkeeper and defenders were starting their celebratory party at the other end. 4-0 at half-time, and we knew that the cup was coming to south London with us.

The start of the second half saw Deepa, who had arrived minutes before the start of the game, cancelling a trip to Liverpool in order to play, proving her worth as she made it 5-0.

In fairness to Bristol, they did provide Juliette, the goalkeeper with one moment to display her talents (?)when they played a long ball through the middle over the defence. In true 'Grobbelar' fashion, Juilette came charging out of her area to beat the Bristol forward to the ball. This only momentarily stopped her by now ecstatic chants of, 'We're Guy's and Tommies, Guy's and Tommies FC...by far the greatest team the world has ever seen.' interspersed with strains of 'You'll never walk alone'.

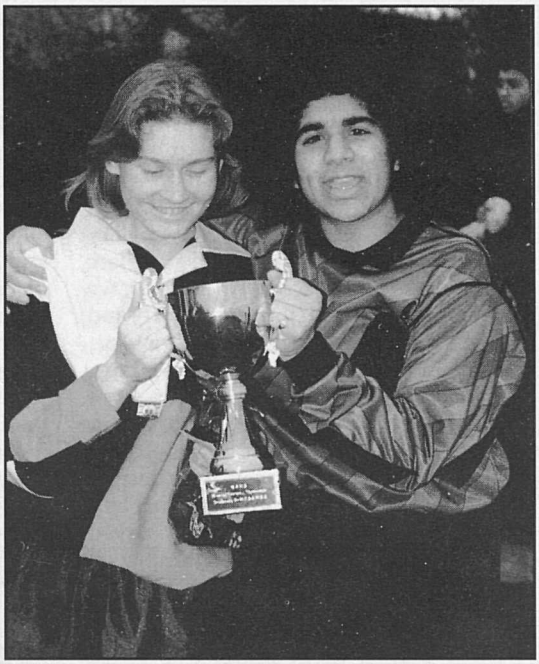
Finally Liz completed her hatrick, scoring our 6th goal, sending the supporters wild and earning herself the nickname of 'Kenny', after that great Liverpool foot-

baller, whose playing she seemed to emulate all match.

On the final whistle there was mass hysteria on the part of the UMDS ladies, as we sang and danced our way to the changing rooms. 'The Boss' collected and held aloof the Cup—our finest hour. All the girls collected their medals, Rashmi promising to staple hers to her CV. The 'winning feeling' lasted well into that evening. Claire, who as usual had played outstandingly in defence, was reported to say nothing but, '6-0', in answer to all questions.

Now that you've heard all about our success you must be interested in playing for one of the friendliest teams in UMDS. Please contact Liz, the new captain. We welcome all ladies and boys (with waxed legs only). It used to be said we had enthusiasm, now we have a cup as well. Thanks to everyone in the squad and here's to next season and winning the league.

Juliet Balakrishnam



Sarah 'The Boss' and Juliet receiving the cup.

Mens Hockey

UMDS II v Royal Holloway and Bedford New College. UL Plate. Won 2-0.

The University of London Reserve Team Cup was introduced this season for the first time and UMDS were not slow in putting a team forward.

We received a bye in the first round and so played our first game against QMWC II. A 2-1 victory, despite a comedy miss was enough to put us through to the quarter-finals. We were drawn against St Mary's III, their second team having been knocked out of the competition. A comparatively easy game resulted in a 2-0 win and the celebration beers began to flow.

The semi-final, played down in Cobham, was a tough game against Imperial College, a team from the league division above us. The fantastic team spirit which had now developed in a side which remained virtually unchanged all season, carried us through to another 2-0 win and the final.

The final was played on Sunday 7 March, at Kings College School Astro. Despite being in the middle of Part II B's we managed to get an almost unchanged side out. We were playing against Royal Holloway II's, a team this time two divisions above us. With some more than enthusiastic support from the 'Mixed Sherry Squad', a spectacular goal by Gary Howsen and a well-taken second by Marc Moncrief (a prolific scorer all season), we had our third 2-0 victory in a row—and the first ever Reserve Team Cup victory.

A mention must be made of the fantastic performances of the defenders (conceding only five goals all season) especially Matt Sabin, Curig Prys-Robert and of course Robin Russell, who despite the need for a zimmerframe now that he's playing his 12 season for the club, played as solidly and energetically as ever. Following the exhausting final game we returned to Motspur Park for a 'swift' half to celebrate. A small group paid a naked tribute to the Women's UL Football final that was unfortunate enough to be in progress at that time.

The following Wednesday the UL league was resolved, UMDS securing an unbeaten first place. The less said about the Open Kent Saturday League, however, the better. I think our not so impressive performance can be put down to the fact that the team were playing 'the morning after the night before'.

A University of London league and Cup double and what was probably the most social side I've ever played for, made this a season to remember.

Team: Rob Hatrick(capt), Guy Barwell, Tim Wells, Gary Howsam, Marc Moncrief, Tim Earl, Paul Nicholson, Robin Russell, Curig Prys-Roberts, Matt Sabin, Ed O'Toole, Til Menge, Jon Sergeant.

Rob Hatrick

The Team.

Netball

UMDS 1st VII v Royal Holloway and Bedford New College. Won 41-31.

The University of London Cup was run this season as a series of fixtures in a knockout tournament running from October to March. We reached the final comfortably, after beating the Royal Vet College (21-13), Imperial College (46-18) and Bart's Hospital (26-16).

This year the UL Cup final was held on 20 March at the Elephant and Castle Leisure Centre. Virtually home ground for us. Within the first few minutes of the game, it was clear that this was going to be the toughest game of the season. At the end of the first quarter we were two goals down. However, we had no intention of losing and a quick reshuffle of the team saw Melanie (the one-handed wonder with a fractured hand) coming on to pick up the pace. By half-time, tension was high with UMDS leading by only one goal (19-18). But, with some storming interceptions from Iddi, we began to gain a strong lead. By the final whistle, we had achieved a convincing score of 41-31, thanks to the efforts of the whole team.

The Team

Thanks must also go to the hordes of Guy's and St Thomas's supporters who kept our spirits up through such a tough and exciting game. Thanks especially to Jon Spencer who gave up watching the Rugby (England v Ireland) in the 'Market Porter' that afternoon.

This result marks another high point in the Netball Club's successes this season, after winning the UH Cup last year. At present both UMDS 1st VII and UMDS 2nd VII stand at the top of their respective divisions in the UL League. Well done to all the Nettie Girls.

Cup winners team: N McDonald (capt), M Buck, K Scanlan, J Jefferson, I Bickell, L Wells, K Powell, C Turrell.

Nicola McDonald

Rugby: 1st XV

Jon Spencer

Guy's 1st XV v Old Regation's 1st XV. Won 27-24.

A beautiful Saturday morning and a rock-hard pitch at HOP set the scene for the first game between OR's and Guy's, playing for the Alex Boulger cup. The game was arranged in honour of Alex who was tragically killed in October.

With emotions running high we were all hoping for an exciting game, and within minutes Steve Lewis was through to score a characteristically selfish try. OR's came back though, and after some sustained pressure scored in the corner. Next a loose ball hacked over OR's try line was ground by Tutton after some impressive running. The forwards at this point started to show great strength. They were rewarded when Roy took the ball at the back of the line out passed to Beardmore who in return slipped a back hand to the robust Murphy who scored.

OR's fought back, and with an impressive miss move their outside centre was through to take the score to 17-21. Guy's front row again showed their dominance by poaching one against the head and Beardmore was over for his second. OR's did some poaching of their own and within 10 minutes had scored two tries, aided by some dodgy back-handling, and were in the lead for the first time in the game with only minutes to go. However after a tense few minutes 'Llanelli' came to our rescue sending Beardmore over for his third try. A relief for all in a very exciting game. Final score 27-24, Guy's.

Team: A Hieath, B Stanhope, J Burt, A Bates, E Barno, W Llewelyn, C Beardmore, R Cunnington(capt), J Murphy, Vince, S Lewis, M Tutton, R Perry, P Crush, M Henderson, M Lewis.

Guy's 1st XV v Westcombe Park. Lost 17-19.

On a gusty morning the 1st XV took on the leaders of London Division 2.

Playing into gale-force winds in the first half, Guy's soon found themselves under pressure. After repeated attempts to breach Guys's strong defences, Westcombe Park eventually succeeded with a try under the posts. This was duly converted, score 7-0.

From the restart Westcombe Park mounted another attack and a missed tackle allowed their left wing a free run to the Guy's try line, 14-0. This seemed to give Guy's a kick-start and an increasing degree of confidence, with the result that Davies and Lewis both came close to scoring. However Westcombe Park had the final say of the first half, with another unconverted try. Half-time score, Guy's 0, Westcombe Park 19.

With the wind behind them Guy's were soon in the Westcombe Park half and after 10 minutes got due reward for their pressure with Gush crashing over in the corner. However Guy's did not use the wind to its full advantage, although Lewis went over, underneath the Westcombe Park goalposts for a well-deserved try, 12-19. Guy's continued to press harder and were rewarded when Jones scored, 17-19. With five minutes remaining Guy's threw everyting into attack and forced a scrum five metres form the Westcombe Park try line. However the referee blew the final whistle to deny Guy's the scalp of the leaders of the League into which they are trying to get promoted.

Team: Rowan, P Gush, A Jones, S Lewis, G MacClennen, N Davies, R Docker,

W Llewellyn, G Ryan, R Llewellyn, E Barrio, B Challacombe, M Searles, B Stanhope, G Tsolakides.

Guy's 1st XV v Old Beccahamians. Won 8-7.

After a hard-fought first half, Guy's were asking,'What more do we have to do?' Having had 80 percent of both ball and territorial advantage they found themselves trailing 0-7 at half-time, the OB try coming from a spilled up-and-under.

In the second half, Guy's dominated possession once again. However lateral running form the Guy's backs and an offside defence meant there was no penetration (um...). But with 10 minutes remaining Ed Barrio, (the Guy's Tower) picked up a loose ball on the OB 22 yard line and sprinted over for the try, which was unconverted. Score Guy's 5, OB's 8.

With one minute remaining Guy's secured clean second phase possession on the OB 22 Yard line. Expecting Guy's to run it, OB's defence hung back as Nigel Davies dropped the sweetest of goals to secure victory for Guy's. Final score Guy's 8, OB's 7. Many thanks to Mrs Spedding for the tea.

Team: M Rosen, P Gush, A Jones, S Lewis, R Breeze, N Davies, R Docker, W Llewellyn, G Ryan, R Cunnington, E Barrio, B Challacombe, A Hyatt, B Stanhope, G Tsolakides.

Guy's 1st XV v Raynes Park. Lost 10-13.

Post-Cup games are always of poor quality and this was no exception.

Leading 10-3 at half-time, through Davies scoring a try, conversion and penalty, Guy's proceeded to throw the game away. An attempt at running the ball from under their own posts led to an easy Raynes Park try, which tied the score 10-10. A further infringement led to Raynes Park kicking the winning goal. Final score Guy's 10, Raynes Park 13.

Team: M Ross, P Gush, A Jones, J Worth, R Breeze, N Davies, R Kushwaha, W Lewellyn, A Skyrme, R Lewellyn, E Barrio, B Challacombe, A Hyatt, B Stanhope, G Tsolakides.

Guy's 1st XV v Purley. Drawn 15-15.

An important league game and Guy's missing key players through injury and bans. What was to happen?

In a changing world, you can always rely on Guy's having a poor start—and we did. Slack defences led to an easy first try for Purley, which they converted 7-0. However straight from that kick-off Andy Skyme charged down a clear angle kick to make the score 7-5. Further pressure, and a quick tap-penalty led to Skyrme racing over again, giving Guy's a half-time lead of 10-7.

In the second half, although fiercely competitive, Guy's supply of ball dried up, giving a dour 30 minutes. However a scrum five metres from the Purley lines allowed Richard Docker to slice through for an unconverted try. Guy's then tried to defend their 15-7 lead, but due to some indifferent refereeing and poor defences, conceded first a penalty and then an unconverted try, allowing Purley to draw level. Guy's were then shaken into action and spent the remaining five minutes on the Purley lines. However, we missed a difficult penalty attempt and gave up a good drop-goal position because of foot-up in the scrummage.

Final score 15-15, giving both sides one league point. A point lost as far as Guy's was concerned. But on a weekend where more than 20 players were unavailable Guy's still managed to field 5 XVs.

Team: N Baker, P Gush, A Jones, J Worth, G MacClennen, S Lewis, R Docker, A Skyrme, R Llewellyn, M Sharp, E Barrio, A Bates, A Wyatt, B Stanhope, J Burt.

Guy's 1st XV v Old Wimbledonians'. *Lost* 5-11.

A large crowd at the Old Wimbledonians' ground, the site of the old St George's Hospital ground, were entertained by a fast and furious match between the current League leaders, who have won all their games, averaging over 35 points a game, and Guy's, probably the most improved side in the League.

Old Wimbledonians have been unbeaten in the League for over two years, and their early control of the ball was so impressive, it was easy to see why. In spite of their reputation as a side scoring lots of points in the backs, on the day, the Wimbledonians' game plan was restricted to a controlled pack performance, and giving the ball to the outside half, an ex-London-Irish player. That they were restricted to this pattern of play was an enormous credit to the Guy's side, who were easily the more adventurous on the day.Guy's controlled their own ball well up front, and tackled furiously throughout the afternoon.

The Guy's side put on a great display in the first half and, after a long period of pressure, almost sent Breeze over in the corner. Most of the first half was in fact played against the slope, and Old Wimbledonians were pinned in their own half much of the time. Just as spectators were expecting a nil-nil scoreline at half-time, Old Wimbledonians made a break-out, and with a driving maul, their pack crashed over for a try. Nevertheless, widespread comment from the spectators—this was the best side that they have seen this season—was music to our ears. Particularly impressive in the first half display was Alex Hyatt, who impressed the home crowd with his ability to lift his opposing prop when the occasion demanded.

After a stirring half-time talk from Captain, Roy Cunningham, a tremendous drive from the forwards took play down to the field and, when the ball was released for a third time, it was sent back to the centre, who scored, but the try was unconverted. There followed a period of Old Wimbledonians' pressure, but wave after wave of Guy's attacks were then neutralised by the long boot of the Old Wimbledonians' fly-half. Guy's tackling throughout was of the highest order. With seven minutes of the match remaining, the score was still 5-5, but a sliced drop-out put the side back under pressure, and the backs were offside, and the ensuing penalty left Guy's 5-8 down. Towards the end of the match, Guy's found it difficult to get out of their own half, and a second offside was kicked, to leave the final score Guy's 5, Old Wimbledonians 11. In spite of the score, the team should have great pride in the way they played, and particular how close they came to upsetting the leaders, who will not get promoted. Let us hope that Guy's will follow them up in the Sesquecentenary season next year.

Team: M Rose, R Breeze, N Baker, J Worth, P Guise, S Lewis, J Murphy, A Hyatt, B Stanhope, A N Other, J Burt, B

Challacombe, G Ryan, R Cunningham, W Llewellyn,

Rugby: 2nd XV

Guy's 2nd XV v Streatham and Croydon 2nd XV. Won 16-15.

On Saturday 27 March, the IIs played away to Streatham & Croydon II. Doubts were expressed at the suitability of this fixture due to the fact that the IIIs had been heavily defeated by the Streatham & Croydon IIIs the previous week.

The match kick-off was delayed due to the fact that Graham McHarg's car had got lost, and nearly ended up in Sussex. Luckily, the channel tunnel is not open!

Having lost one player from illness at the last moment, we drafted in one of the Streatham & Croydon supporters at number eight. Guy's conceded an early try in the first five minutes.The pack, however, was showing dominance in the scrums and the loose play. One nasty moment occurred when Mike Seare was punched. A penalty from Ed Hughes pulled Guy's back again, but another Streatham & Croydon try made the half-time score 10-3, Stretham.

The second half started badly, with Guy's conceding another try. Hughes, however, converted two more penalties to make the score 9-15. Then, in the last five minutes of the game, Guy's won a scrum against the head in Streatham & Croydon's 22 yard line. Matt Tutton then burst through the Streatham & Croydon centre to score between the posts. Hughes converted, and the game was won.

Team: M Seare, J Spencer(Captain), K Ivel, R Dales, A Bates, G McHarg, M Giles, P Goodyear, E Hughes, M Tutton, G McClellan, M Henderson, C Smith, E Wallis.

Guys 2nd XV v Charing Cross and Westminster 2nd XV. Hospital's A-Cup final. Won 17 -10.

A blue sky, a large crowd of enthusiastic, sober and well-behaved supporters at London Welsh, this was the setting of the first cup final in recent years for the Rugby club. We faced the large and well-drilled CXW team that had beaten us in the past two years.

Within minutes CXW had swooped on a loose ball fumbled at the back of the scrum and were seven points up. However Guy's, shocked into action, fought back and after 10 minutes of pressure found themselves with a line out on CXW's try line, whereupon Mike Seare, inspired by the occasion, caught the ball and dived over the line amidst a euphoric crowd. Playing well, we kept the pressure on and found ourselves with a penalty in CXW's 25, using our only move Ross Llewelyn powered through the CXW pack to put us ahead.

The second half was characterised by intense pressure from CXW and stout defending by Guy's, until the issue was put beyond doubt by an opportunistic charge down and follow up by Graham Lawton, as he did against St Mary's.

On hearing the final whistle there were wild celebrations as we realised we had won the cup for the first time since 1973. We were all very proud to receive the cup from Mr Hawker, father of James, who himself had been the captain of the original team. It was a great day for the Rugby club and was duly celebrated.

Team: Mike Seare, Jon Spencer(Capt), Ken Ivil, Pete Davis, James Thalon, Ross Llewelyn, Graham Lawton, Andy Skyme, John Murphy, Neil Davies, Matt Tutton, Ross Perry, Mark Howells, Guy McCellan, Ronan Brown.

Death

CRIPPS, Norman LDSRCS (Eng) 1937, died on 9 March 1993. Formerly of Caterham. Dearly loved husband of Margot and father of Stuart, Guy's BDS 1969, Martin and Sarah, Guy's SRN 1975.

Golden Anniversery

The Golden Anniversery of Dr and Mrs Harley celebrate their Diamond Anniversary, at their home in Cape Town, on 28 June 1993.

Copy for the *Gazette*

Articles for inclusion in the *Gazette* should be supplied double spaced, and preferably word-processed or typed. If handwritten, names in particular should be written legibly. If contributions are prepared on a word-processor, it would be particularly helpful if a floppy disk containing the article is supplied along with a printed copy. Where possible, text should be saved in ASCII format—or if in any doubt, full details about compatibility of different files can be obtained from the *Gazette* office.

All feature articles should be received by the dates below, and should be approximately 1,500 to 2,500 words in length. Late news and sports reports can usually be accepted upto one week later. This deadline may also be extended by agreement with the editor. Authors are requested to supply a contact phone number in case of any queries that arise. The *Gazette* would also particularly welcome results of any original research carried out in the course of BSc or other project work. Final year students are requested to send in material about their electives—even if it only consists of anecdotes.

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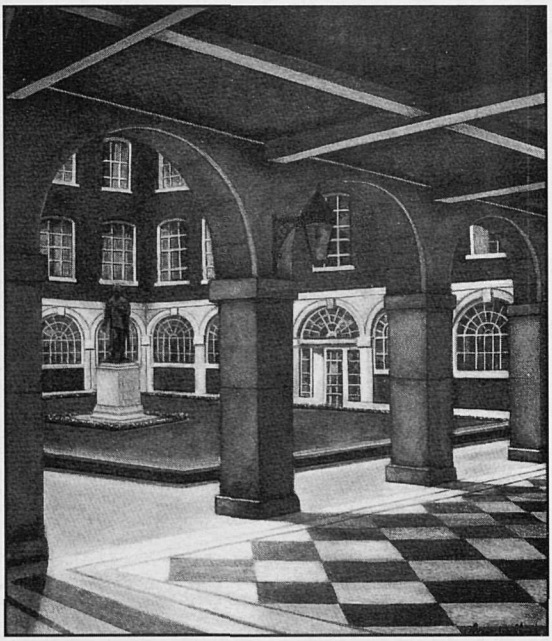

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GUY'S

HOSPITAL GAZETTE

UMDS Guy's
- 6 SEP 1993

July—August 1993

- New Doctors and Dentists—List of Qualifiers
- Organ transplantation—the pioneers at Guy's
- Club Union and Rugby—End of Year Summary

London Bridge, Southwark side.

CONTENTS

222 **Passim**

223 **Letters**—Views on nursing

225 **News**—Speciality reviews

228 **Organ transplantation**—the pioneers at Guy's

240 **The finals challenge!**

244 **50 years on**—Wartime rugby at Guy's

250 **The Perversity of Inanimate Objects**—by J H Pitt-Payne

255 **Reviews**—Help on disk

255 **Clubs Union News**—Year summary

257 **Nursing notes**—Sister Nora Relihan

260 **Sport**—Rugby, rifle and squash

264 **Classified and announcements**—list of qualifiers

UMDS Guy's
-6 SEP 1993
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Guy's Gazette

Editor Romila Bahl **Sub-Editor** Mark Dayer **News Editor** Robert Self **Sports Editor** Ken Ivil **Book Reviews** Saikat Banerjee **Nursing Notes** Denis Cobell **Office Manager** Margaret Flanders.

The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

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Passim

Media comment and debate during mid-August appears to have been dominated by one subject, the airlift of selected persons urgently requiring medical attention out of Sarajevo. This action has caused a flurry of controversy and criticism of all aspects of its aims, seen effects and possible repercussions. Some believe that the resources used would have been better deployed towards further improving hospital facilities in affected areas; a view countered by those who consider the most effective way of helping is to remove people from war-troubled regions and use established facilities in Europe. Whatever one's opinion of the actions taken, the resurgence of public interest will, it is to be hoped, result in further resources and help for those affected. As the war continues it is claiming not only 'blast-wound' casualties but also those with ongoing medical conditions. What it feels like to be an insulin-dependent diabetic in Sarajevo is something that, in England with assured medical care, one can only hazard a guess at.

Dennis Bogdanovic, an eight-year-old child from Sarajevo, is currently under the care of Dr Shak Qureshi, paediatric cardiology, Guy's. On the day of writing this passim Dennis was due to undergo a replacement of his stenosed aortic valve. His condition, said Dr Quershi was correctly diagnosed in Belgrade hospital three years ago and would have been treated there had not the present situation developed. The delay has resulted in left ventricular hypertrophy and a decrease in his chances of survival post-surgery. The money for his treatment has come from somewhere in central Government.

*Moving from one subject where it appears impossible to please every-*one, to another. The Trust board, at its meeting on 5th August agreed to put back by one month the submission of its recommendations, of future strategy and site appraisal, to the Secretary of State for Health. The additional month will allow further work and analysis of future income and site options, to be undertaken. With the far-reaching implications of these recommendations and also the inevitable disruption that any change causes, one cannot but agree that 'our recommendations are properly considered.' However it cannot be easy for departments within the two hospitals to plan for the coming months with their allocations and sites undecided.

The good old days

Dear Sir,
Mr Denis Cobell in his recentarticle in the *Gazette* refers to his conception of nursing in what he terms, 'the good old days', when (so he says) nurses were often nasty to patients and thought it within their rights so to be, patients were told what to do and the word of Sister was sacrosanct. Although not given to exaggeration, I admit to being horrified at such representation of Guy's nurses in the not so distant past.

It is nearly 50 years since I was a very young junior probationer in our hospital, but I have never forgotten the first thing that we were taught when initiated into the then Preliminary Training School. This was that the patient was not a body, not a number and not an object, but a human being with feelings and rights. We were also encouraged to widen our outlook as much as possible, by going to the theatre, concerts, films and to read, so as to make ourselves of more interest to our patients, whatever their background. Indeed, Guy's nurses so one heard, were known for their intellect over many generations.

I would fail to agree with him, however, in his consideration of, ' the good old days' as far as nurses were concerned. I cannot imagine a young student nurse ending up in Matron's office for singing in the sluice now, which was my fate on more than one occasion.

Yours faithfully,

VALERIE TAYLOR
SRN
Guy's Hospital

Sister Relihan

Dear Sir,
The departure of Nora Relihan to her home in Ireland marks the end of a unique and unrepeatable period of continuous service to Guy's. Immense change and development has taken place at Guy's since her arrival in October 1942. Then the only Guy's building on the East side of the Great Maze Pond was the College, opened by Mr Gladstone a mere 52 years earlier. Now Philip Harris House is about to join the Tower and New Guy's house is a complex of buildings extending all the way to Weston Street; union with St Thomas's is imminent.

In her nearly thirty years as Sister of Barnabas ward she worked with many famous Guy's men. Together with Ruth ward, Barnabas housed neurology, dermatology and eye patients. When Sister Relihan was appointed, the consultant eye surgeons were Gayer Morgan, Frank Law and Charles Cook. On the dermatology side she started with Hugh Barber and Louis Forman. The neurologists were Sir Charles Symonds and Sean McArdle. Ian Mackenzie followed Symonds in 1955 and Richard Hughes took McArdle's place in 1975. Relatively few senior registrars covered this long period—Ian Mackenzie, Christopher Earl, Findlay Campbell, Raymond Lascelles, John Hern and Michael O'Brien. The list of middle grade registrars is too long to give here, but some distinguished physicians spent a year in this post to learn some neurology, including Charles Joiner, Dennis Duechar, Ian Roberts and Robin Stott.

Sister Relihan came from a world now sadly past, when not only were the highest standards of nursing rigorously prac-

tised but the ward sister was, in the words of Victor Medevi, '...guide, disciplinarian, counsellor, teacher and friend to students, housemen, chief assistants, honoraries and professors'. It was always a pleasure to have patients on Barnabas, which ran smoothly and without fuss, an oasis of calm within the hospital. Although doctors were allowed onto the ward without sister's permission, medical students certainly had to ask before they saw a patient. Any ancillary staff had to wait outside before Sister allowed them in. Her office throughout this time was a narrow slit of a room with very limited seating capacity, so that tea with Sister Relihan, was an honour accorded to few and much sought after.

On retiring from Barnabas her career at Guy's took an unusual turn. Her great experience as a neurological nurse made her an invaluable assistant to the consultant in electromyography, Dr J Payan, with whom she worked for a further 12 years. She welcomed, reassured and prepared patients for an investigation of which they had usually been told nothing and often feared the worst. It was also her responsibility to prepare the equipment, help to operate it and act as amanuensis. This lively continuation of her work for neurology at Guy's proved a source of strength in increasingly difficult times.

There can be few living Guy's men and women who have not come across Sister Relihan at some stage in their careers. Even if they once stood in awe of her they will remember her with admiration and affection and will wish her happiness in retirement. Her many friends in England ask only that she will return to visit them from time to time.

DR J PAYAN
Department of Neurology

Speciality review results

The results of six speciality reviews carried out on behalf of the Government have recommended that the Guy's and St Thomas's Trust be a major centre for each of the six. The specialities reviewed were the cardiac, neurosciences, oncology, plastic sugery, renal and specialist paediatric services.

All of the reports recommend a significant role for the Trust in providing these services in London. An important development will be the addition of a larger neurosciences centre. This is the only one of the above specialities for which the trust is not already a major provider in South and Central London. Unfortunately the reports also suggested that Paediatric Cardiology be transferred from the trust to the Royal Brompton Hospital. The response to the recommendations of these reports remains a decision for the Trust Board.

Eight Group Directors have been appointed by the Trust. This is the final stage of the new clinical management structure. The Group Directors will oversee the management of the Clinical Directorates, and will also sit on the Trust Executive to reflect the views of their groups. The Group Directors are:

Prof Frank Ashley (Guy's)
Dr Brian Ayers (St Thomas's)
Dr Nigel Bateman (St Thomas's)
Dr Michael O'Brien (Guy's)
Mr Crawford Jamieson (St Thomas's)
Prof Ian Phillips (St Thomas's)
Dr Michael Richards (Guy's)
Prof Gwyn Williams (Guy's)

University of London response to speciality reviews

The University of London is increasingly concerned that UK medical research could be seriously harmed by some of the recommendations in the speciality review reports.

Professor Colin Dollery, Pro Vice-Chancellor for Medicine and Dentistry, University of London, emphasizes that there has been no financial analysis of either capital costs or anticipated savings to underpin any of the proposals. However, capital needs to be available to create new facilities for teaching and research before old facilities close. He says, 'There has been a failure to consider the impact of a series of individual decisions on whole hospitals and associated medical schools. The reviews have been mapped out by individual teams dealing with individual specialist institutions, in a completely unrelated fashion so that the current recommendations do not add up for a plan. The speciality reviews have been driven almost entirely by service considerations. The University regrets that insufficient importance has been given to preserving London's great strength in medical research and teaching.'

'To the Lighthouse' charity cycle ride

The sixth 'To the Lighthouse' sponsored bike ride will take place on Sunday 12th September. The ride will raise money for three charities: The London Lighthouse, The Landmark and Great Ormond Street Children's Hospital. All of these organisations are involved in caring for people affected by the HIV virus.

The ride starts on Richmond Green, South London, and follows a scenic 33 mile route to end in the grounds of Losely Park. This year there are two prizes specifically for team entries—the company team and the social team raising the most money. For further details and an entry form, contact: 'To the Lighthouse, PO Box 8, Bristol, BS99 5BS, 0272 2277668.

Smoking policy

The UMDS smoking policy took effect on the 1st July. Staff, students and visitors are only allowed to smoke in designated areas. Smoking is not allowed near public entrances to the school or hospital or in any corridors, fire escapes, toilets or storage areas. The bars in Boland House and St Thomas's House are smoking areas, but the dining rooms are not.

Presentations

The presentation ceremony for Final Year medical students was held in Southwark Cathedral on Thursday 8th July.

On Wednesday 13th October a presentation ceremony for BScs, higher degrees and honourary fellows will be held at 3.00pm in Southwark Cathedral. Those receiving honourary fellowships include:

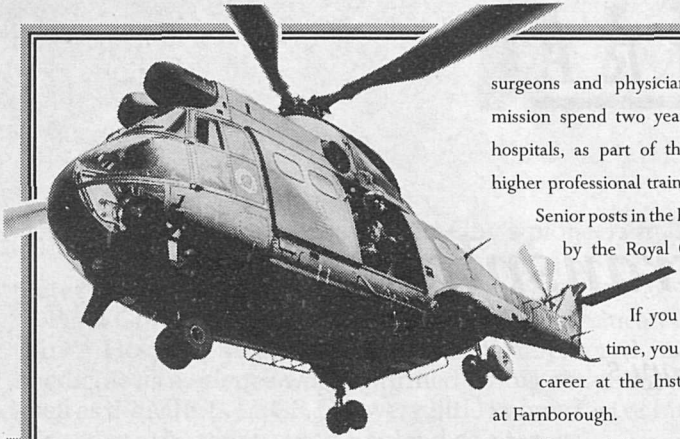
Dr Brian Creamer
Sir Terence English
Dr J C Houston
Lord Owen
Lord Richardson
Dame Cicely Saunders
Mrs R Travers

Evelina Children's Appeal museum project

There is a proposal to establish a permanent exhibition of the history of the Evelina Hospital for Sick Children and Guy's paediatric department in the existing old operating theatre museum and herb garret, St Thomas's street. This project is in co-operation with the special trustees, the Evelina appeal and Mr Kevin Flude, curator of the museum.

Any help from *Gazette* readers would be appreciated, for example donating or lending any historical documents, objects, equipment and stories, anecdotes etc, which might be of interest.

Information about the museum project may be obtained from Michael Joseph, Evelina appeals office, Henriette Raphael House, Guy's Hospital, 071 403 4089.



surgeons and physicians on a permanent commission spend two years' further training in NHS hospitals, as part of the four-year programme of higher professional training.

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Organ transplantation

The pioneers at Guy's

In 1991, two books were published which consist of reminiscences by many of the major pioneers of organ transplantation worldwide Each contributor provides an account of his or her recollections and experiences. Of the total of thirty contributors in the two volumes, no fewer that four have Guy's connections—two immunologists, Bernard Amos and Richard Batchelor, and two surgeons, Sir Roy Calne and Folkert Belzer. Furthermore, several contributors included reference to the work of another major Guy's transplantation immunology pioneer, Peter Gorer, who sadly died in 1961 at the early age of fifty-four years.

Amos, Batchelor and Calne are all 'true' Guy's men, as was Gorer, having studied medicine at Guy's Hospital Medical School. Belzer, educated in medicine and trained in surgery in the USA, is an 'adopted' Guy's man, having spent a year in the Department of Surgery at Guy's as a senior lecturer, in 1963-64.

The leading role that this group of Guy's men has played in the development of organ transplantation was highlighted at the 14th International Congress of the Transplantation Society in Paris in August 1992. Of six pioneers honoured at that meeting, two of them, Amos and Calne, are Guy's men. The Congress, attended by over 2,000 physicians and scientists, opened by honouring tissue immunologist Bernard Amos, Jean Dausset (from France, and a Nobel Laureate in 1980) and Jon van Rood (from the Netherlands) for their contributions to the field of histocompatibility. The Medawar Prize—the premier award of the Society—was awarded jointly to surgeons Tom Starzl, Norman Shumway (both from the USA) and Sir Roy Calne for their advances in the field of organ transplantation.

Amos was the Founder President of the Transplantation Society, Batchelor was the President in 1990, and Calne is the current President.

I felt that it would be of interest to Guy's men and women to learn the role that each of these five men has played in the development of organ transplantation. Brief summaries of the four individual reminiscences are outlined in this article, and some comments on Peter Gorer, gleaned from several contributions from these two volumes and elsewhere are added.

I have chosen to begin with these comments on Peter Gorer, as, chronologi-

cally, he is clearly the earliest of the Guy's pioneers in this field.

Peter Gorer

Peter Gorer was born in London in 1907, and educated at Charterhouse and Guy's Hospital Medical School, which he entered in 1924. His interest in medicine as a science was confirmed by his obtaining a BSc in physiology as well as the MRCS, LRCP. One very little known fact of his youth is that, despite his asthma, he represented England as a fencer.

After leaving Guy's in 1932, Gorer joined J B S Haldane at University College, and in the stimulating atmosphere of that department he developed an interest in genetics, which later played so large a part in his researches. In 1934, he was appointed to the staff of the Lister Institute, and it was while he was there that he began the study of the genetic and antigenic basis of tumour transplantation which occupied him almost exclusively for the next twenty-five years.

In 1937, at the age of thirty, he published the first of two seminal papers. These were important, not only in stating an advance in knowledge in the field which was to be his life's work, but in the influence they has on others. Although it was some time before the significance of his work was recognised throughout the world, or the practical implications of it in the surgical use of allografts was realised, the first sure step was made then.

Their subject is the relationship between the antigenic composition of tumours, and the factors that are responsible for their growth or destruction when transplanted into other members of the same species. In Gorer's work, the species studied was the mouse.

Gorer's great innovation of the principle was to correlate suscep-

Peter Gorer

tibility or resistance to the growth of the tumour with the presence or absence of an antigen (Antigen II) known to distinguish two different strains of mice (A and c57). Although he used haemagglutinating antibodies as indicators, he found that the possession of Antigen II was not a property peculiar to red cells; ordinary tissue cells also possessed it. Gorer found that the transplantation of an A-strain mouse sarcoma into C57 mice excited the formation of an antibody directed against Antigen II—the first 'iso-antibody' to be discovered in mice.

When Gorer later worked at the Jackson Memorial Laboratory in Bar Harbor in the USA, a colleague there, George Snell, suggested that the genes governing transplantation should be called histocompatibility genes. The locus tenable by the allele associated with the formation of Antigen II became Histocompatibility-2 (H-2). Gorer, therefore, along with Snell, is credited with the major discover of tissue groups in the mouse, which laid the genetic foundation for the entire field of tissue transplantation and immunogenetics.

In 1940, the year in which he obtained the DSc degree, Gorer returned to Guy's. After the war years, George Payling-Wright, the Professor of Pathology, gave him great freedom to pursue his research interests. Apart from the one year he spent in the USA, he remained at Guy's until his death in 1961, expanding his work on tumour and transplantation immunology and genetics with the help of a succession of very able junior colleagues.

His stature and importance were increasingly and universally recognised. In the year before his rather sudden death, he was elected a Fellow of the Royal Society—a rare distinction for Guy's graduates in recent years—and plans were made for a University of London Chair in his own Department of Immunogy at Guy's.

Sir Peter Medawar, writing at the time of Gorer's death (4), states, 'Peter Gorer was the World's leading authority on the manifold problems of tumour transplantation and on the serology of the homograft reaction generally. Nearly twenty-five years ago, when he was only thirty, he published two papers in the *Journal of Pathology and Bacteriology* which laid the foundations of modern research on the immunological genetics of transplantation: he discovered haemagglutinating antibodies in the blood of mice bearing homografts of tumours, and showed that the power to excite the formation of these antibodies went hand-in-hand with the properties that called forth resistence to the foreign growth.'

Elsewhere (5), Medawar states Gorer's scientific position even more succinctly. 'His position in science is not difficult to define. He was the World's foremost authority on the serology and serological genetics of tissue transplantation.'

In a salute to Sir Peter Medawar (2), Rupert Billingham, Leslie Brent and

Avril Mitchison state that, 'Peter Medawar—together with Peter Gorer and George Snell—is rightly regarded as the man who established the science of transplantation immunology.' Gorer is, therefore, placed in illustrious company as Medawar was awarded the Nobel Prize in Physiology or Medicine in 1960 (which he shared with McFarlane Burnet), and Snell shared the same prize in 1980 (with Jean Dausset and Baruj Benacerraf).

George Snell, who was awarded his prize for his work on the H-2 histocompatibility system in the mouse, writes, 'One other lone pioneer, and a very important one, Peter Gorer, whose early works substantially antedated mine. His approach was serological—the identification of antigenic differences between strains (of mice) ... I did not learn of it (Gorer's 1937 paper) until Gorer came to the laboratory (in Bar Harbor) in 1946 for a year of co-operative research. The main outcome of this joint study was the demonstration that the locus that Gorer had identified serologically (Antigen II) and the locus that I had identified by linkage studies were one in the same, the locus designated H-2.' (2).

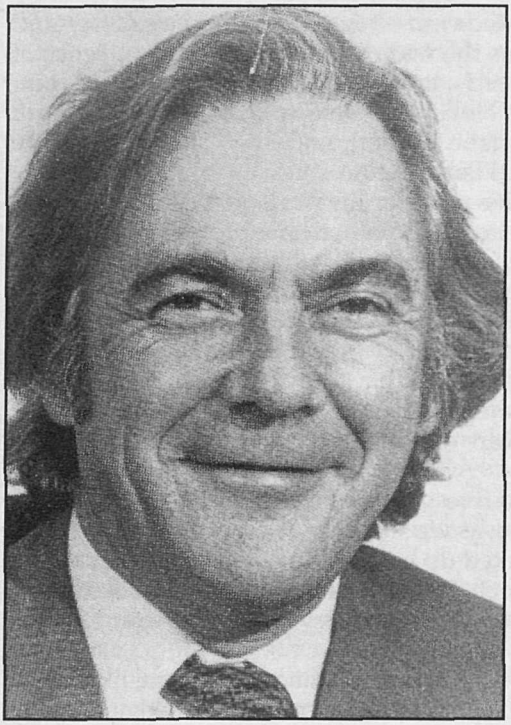
Snell continues, 'Over a twenty-five year period, Gorer was author or co-author of numerous papers. Also, as we shall see, his serological approach to transplantation antigens was picked up by other investigators and became a mainstay of transplantation research. So important was this area, that had it not been for Gorer's untimely death, he might very well have won a Nobel Prize.'

From the comments of these several individuals, it seems quite likely that Guy's might have had a Nobel Prize Winner if Gorer had not died at an early age. The Nobel Prize is not awarded posthumously.

Bernard Amos

Bernard Amos was born in 1923 in Bromley, educated at Bromley County Grammar School, and, after a period as a laboratory technician, studied medicine at Guy's, qualifying in 1951. Amos was house surgeon to Mr Glover (general surgeon), then to Mr Falconer (neurosurgeon), and house physcian to Sir John Coneybeare and Dr Hardwick, before moving to the Pathology Department, where he worked with Peter Gorer from 1952 until 1955.

His own later interest in transplantation immunogenetics was secondary to the interest in immunity to tumours he developed at Guy's. Amos, working with Gorer, was probably the first to describe a tumour-specific antigen in 1956. Amos writes, 'The medical degree gave me the freedom to spend the rest of my life doing what I wanted to do. Working with Gorer exposed me to one of the finest minds in medical research.' (2). The rest of his career has been followed in the USA, initially in Buffalo, and subsequently at Duke University



Bernard Amos

Medical Center in Durham, North Carolina, where he is presently James B Duke Professor Emeritus of Immunology and Experimental Surgery.

In 1961, Amos was invited to Duke University to help establish the genetic basis for a new kidney transplant programme. The first necessity was to set up a test system for detecting tissue antigens in man. White cells were the targets and leucoagglutination was chosen as the test. Leucocytes as carriers of transplantation had been identified as such by Medawar in the 1940s, and Amos himself had shown in 1953 that the mouse H-2 antigens could be identified by leucocyte agglutination.

The method he and his colleagues set up had several advantages over previously published methods, but they soon changed to the cytotoxicity technique which remains the standard technique today. The period from 1962-65, saw a marked evolution in their ability to define antibodies. Their early work consisted of testing serum samples for antibodies and comparing the results with skin grafting between various members of a family to ascertain the best possible donor of an organ. The potential kidney recipient, who could not receive a skin graft from the potential donors for fear of sensitisation, donated skin to siblings who also exchanged skin with each other. Antigens were detected by agglutination and cytotoxicity, and the degree of compatibility, was scored as the numbre of incompatibilities detected.

In the Duke programme, their first kidney transplant was performed in 1965, and was one of the first cases in which donor selection was based on histocompatibility. The donor was chosen from one of seven siblings of the recipeint. All of the other siblings were excluded because of antigenic incom-

patibility. The patient was treated with azathioprine and prednisone alone, and the transplant served him perfectly for more than twenty years before being replaced. Amos reminds us that the early patients who underwent kidney transplantation were almost moribund, as there was frequently no dialysis programme available to them.

Of the first six patients transplanted at Duke, five, who were judged most compatible, had functioning grafts seven months or more after transplantation, and three never required even steroid therapy. It must be remembered that this was in the days well before cyclosporine became available.

Phenotypic matching was obviously advantageous in families, but, unfortunately, it was soon found that it was much less successful in unrelated donor-recipient pairs. Further investigation was required, and Amos, working with Fritz Bach, played a major role. Their group established that the main system, Hu-1 (subsequently known as HLA) controlled mixed lymphocyte cell reactivity, leucocyte antigens, and skin graft reactivity. Amos found that several antigens were inherited as a genetic unit, called (by Ceppellini) the 'haplotype'. Amos and his colleagues demonstrated that the degree of stimulation was related to the difference in the number of haplotypes shared.

Nobel Laureate, Jean Dausset, takes the story further (1), 'The second major phase in the HLA adventure was the discovery of yet another major HLA locus in close proximity to the HLA-A and B. This locus controls the expression of what is known today as the class 2 HLA antigens. The first indication of their existence in man was provided by Bernard Amos and Fritz Bach in their observations that mixed lymphocyte culture tests performed between genotypically HLA-A and B identical siblings could, on rare occasions, stimulate a proliferative response. This result suggested that a recombinant event had occurred in these families, between the two known HLA-A and B regions, and one or more of the genes postulated to govern mixed lymphocyte reactivity. This marked the birth of the HLA-D series.'

Of perhaps equal importance was the significant role Amos played in the development of the South East Organ Procurement Foundation (SEOPF) in the USA, which was one of the earliest organ sharing networks to develop. SEOPF came into being because of the relationship that grew up between transplant surgeons and immunologists at a handful of centres in the south-eastern USA. All SEOPF centres used the same serum panel for typing donors and recipients, and conducted a series of workshops to minimise variations in procedures between laboratories. Donor/recipient matching was co-ordinated through a computer programme. As computer matching grew more sophisticated, SEOPF could increase the number of centres participating, and eventually is spawned the United Network for Organ Sharing (UNOS), that

is now the paramount donor organisation in the United States.

He was also a leading member of the advisory committee of the transplantation and immunology programme of the National Institute of Allergy and Infectious Diseases. A serum bank was developed to allow increased tissue antigen identification. The sera became extremely well characterised because of the established users were required to report their results to the bank. During one particularly important meeting in 1967, the terminology of the human leucocyte antigen (HLA) system was debated, the designation HL-A was formally agreed upon, and the first HL-A antigens were defined.

The first meeting of the WHO Leukocyte Nomenclature Committee, which took place in New York in 1968, consisted of just thirteen people, including Amos and Richard Batchelor.

Bernard Amos was also a major participant in the histocompatibility testing workshops that played a very important role in the development of tissue immunology. Leading Dutch immunologists, van Rood and van Leeuwen, credit Bernard Amos as taking, 'The initiative for the first histocompatibility workshop' (1), which was held in 1964 in the National Academy in Washington, with a workshop in Duke University. It centred mainly around a comparison of techniques.

Indeed, the Transplantation Society, now the major society for those interested in organ transplantation, arose indirectly from these histocompatibility workshops. Informal talks were held between several interested in organ transplantation about starting an international society. Amos was asked to become chairman of the steering committee. In 1965, a constitution was hammered out, which was put to a membership that was hastily elected during the seventh transplantation conference of the New York Academy of Sciences. Peter Medawar, who had not been greatly involved in the early formative stages of the society, was a unanimous choice for the first president. Jean Dausset asked if Amos would accept the title of Founder President. This title was later changed to Past President, and Amos was duly elected.

Amos recollects that he found these to be exciting and often turbulent years, marked at times by unselfish co-operation and help, and at others by intense competition. He and his colleagues laid a solid genetic basis for organ transplantation, defined many of the HLA loci and their alleles, and developed the concept of the haplotype.

Sir Roy Calne

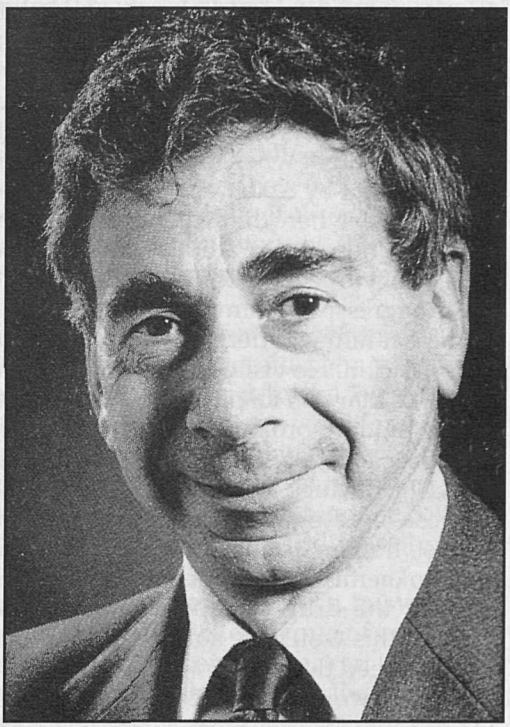
Roy Calne was born in London in 1930, attended Lancing College, and received his medical education at Guy's. Between 1953-54 he held the appointments of house physician to Drs Hampson, Kauntze, Douthwaite and Mann,

and house surgeon and thoracic house surgeon to Mr Eckhoff and Sir Russell Brock (later Lord Brock). Since 1965, he has been Professor of Surgery at the University of Cambridge.

In an exceedingly distinguished career, he was elected a Fellow of the Royal Society in 1973—a rare honour for a surgeon—and was awarded the Lister Medal of that society in 1984. Between 1987-89, he was Vice-President of the Royal College of Surgeons of England. He was the Founder President of the European Society for Organ Transplantation, and is the current President of the Transplantation Society.

Roy Calne has certainly been the major surgical figure in organ transplantation in Britain during the last thirty years. His interest in transplantation began when he was a medical student, observing many fatal diseases in young people when all they required were new organs. He was particularly stimulated at Guy's by the consistent lack of encouragement and negative response with which his naive suggestions were met !

Taking care of a young man of about his own age with Bright's disease (in Guy's Hospital, where Bright had worked) he was told by the senior consultant that he would have to make the patient as comfortable as possible for the two weeks of life that remained. Calne asked if the patient could receive a kidney graft, and was told, 'No'. To his question of why not he was told, 'Because it cannot be done'. Further inquiry would clearly have been interpreted as rudeness, and so he did not persist. However, his group of students discussed the matter afterwards and, apart from some science fiction vaguely recalled, it appeared there was no hard information available. He later realised they were wrong because, by the early 1950s, a considerable amount of



Sir Roy Calne

scientific work had already been done.

Whilst teaching anatomy at Oxford University in 1956, Calne attended a science lecture given by Peter Medawar, in which he outlined the exciting story of immunological tolerance. The next day, Roy Calne asked the Head of the Department of Anatomy, Sir Wilfred Le Gros Clark, who was a friend of Medawar, if he would write a letter recommending him to join Medawar's laboratory to study transplantation. Le Gros Clark replied that, as Calne wanted to be a surgeon, it would be far more beneficial for him to go and learn how to do hernia operations instead.

Shortly afterwards, Calne became a registrar at the Royal Free Hospital, and arranged to carry out animal research at the Buckston Browne farm in Kent. He set about transplanting kidneys in rats, but found the technique difficult and had little success. He was then allowed to transplant a kidney in a dog. He was untrained in vascular surgery, and the facilities were exceedingly primitive, the surgical light consisting of an Ovaltine tin in which was an ordinary light bulb. His first attempt at an autograft was successful, but his next ten tesulted in technical failures.

He then arranged to study the application of total body X-irradiation on the immune response, and was permitted to irradiate dogs at the Royal Marsden Hospital at night whent he facility was no longer needed by patients—as long as he was out by 8.00 in the morning . The senior technician in the cobalt unit showed him where the switches were, worked out the dose he should use, and then went home . X-irradiation produced severe depletion of the bone marrow with pancytopenia, yet, disappointingly, the dogs were able to reject their grafts aggressively, almost as quickly as non-irradiated dogs.

This set him wondering whether anti-cancer drugs might be an alternative to irradiation. He visited Dr Kendrick Porter, who was then a junior pathologist at St Mary's Hospital, and who had some experience using thiotepa, to obtain modest prolongation of skin grafts in rabbits. Porter drew Calne's attention to a paper in that week's edition of *Nature* by Schwartz and Damashek, which has since become a classic.

These investigators had prevented rabbits from producing antibodies against human serum albumin by treating them for two weeks with the anti-leukaemia drug, 6-mercaptopurine (6-MP). Moreover, this effect persisted after the drug therapy had been discontinued. Both Porter and Calne thought this would be a much more promising approach than X-irradiation. It was agreed that Porter would study 6-MP's effects on skin grafts in rabbits, and Calne would see if he could prolong survival of canine renal allografts.

After some weeks' work, Calne was successful in prolonging renal allograft survival, and telephoned Porter to give him his results. Before he could impart

his news, Porter said, 'Do you remember the 6-mercaptopurine experiments? Well it did not have any significant effect on rabbit skin allografts, so I wouldn't bother to try it in the dogs.'

John Hopewell, his encouraging and supporting senior at the Royal Free Hospital, agreed to use 6-MP in clinical kidney transplantation. A potential donor was admitted, but unfortunately found to have polycystic kidneys herself.

In order to give himself the opportunity of working on transplantation research full-time, instead of part-time whilst trying to fulfill the demands of a busy clinical job, Calne obtained a Harkness Fellowship to spend a year at the Peter Bent Brigham Hospital in Boston, where there was one of the World's few active kidney transplant programmes at that time.

On arrival in New York, he took a train to the Burroughs-Wellcome Laboratories in Tuckahoe, where he met chemists, George Hitchings and Trudy Elion, with whom he had corresponded. He was received with great friendliness by these two scinetists, who had synthesized a number of purine and pyrimidine analogues designed especially for the treatment of cancer, for which work, in 1989, they shared the Nobel Prize. They gave him several analogues to investigate in renal transplantation, and he arrrived with these in his briefcase at the Birgham to work with Dr Joseph Murray (recipient of the 1990 Nobel Prize for his pioneering work in kidney transplantation). BW57-322, an analogue of 6-MP, seemed to be the best of these agents, and was a little superior to 6-MP. It became known as azathioprine (Imuran), and has remained a basic constituent of immunosuppressive programmes ever since.

On his return to England, Roy Calne took up a post as senior registrar at St Mary's Hospital, and introduced azathioprine and steroid therapy into the kidney transplant programme there. When he moved to the Westminster Hospital a little later, as a senior lecturer, the theatre sister would not permit cadavers in her operating room, so the removal of donor kidneys was carried out in the open wards. Calne reflects on the disturbing effect this must have had on the other patients as they watched the surgeons go behind the curtains to operate on a corpse in bed, with, on occasion, blood trickling out on the floor.

In 1965, Calne moved to Cambridge and soon established a busy kidney transplant service. He also set about developing the technique of orthotopic liver allografting in the pig. This required much perseverance in the face of many disappointments, but eventually his group showed that liver allografting could make the animal tolerant to other tissues from the same donor, the first demonstration of tolerance in immunologically mature animals without

the use of immunosuppressive agents. Unfortunately, this has been impossible to duplicate in human subjects, and the cause for the development of such tolerance in pigs remains uncertain.

With considerable opposition from many of his colleagues, Calne began a clinical liver transplant programme at Cambridge in 1966, which rapidly became the major programme in Europe, and has proved an important training centre for sugeons interested in this field.

In the laboratory, Calne's group continued to search for better methods of immunosuppression, with the aim of eventually producing tolerance. Jean Borel's work on cyclosporine became known to him, and it was in Calne's unit that much of the early animal experimentation with this drug was carried out. His team investigated cyclosporine in dogs with kidney grafts, and in pigs with orthotopic heart grafts, and found the drug to be far better than any other agent previously examined in any of these models. A pilot study was carried out in man and established its efficacy as an immunosuppressive agent in clinical practice. With azathioprine and corticosteroids, it has, today, become the mainstay.

David Cooper

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The finals challenge

'They were so lovely'

Ivan Petrovich Pavlov could have saved a fortune in meat bills, and spared his neighbours countless sleepless nights if, instead of dogs and bells, he had used junior doctors and bleeps to demonstrate the conditioned reflex. The bleep, which one foolishly covets as a student, as it is the quintessence of being a doctor, in fact rapidly becomes the bane of one's life upon qualification. When it sounds, the pulse rises and the spirit falls. Soon, every time a doorbell or telephone rings, one irresistibly looks down at the pocket in which the loathsome bleep lies—watch the junior doctors enjoying a nutritious MacDonald's supper when the chip machine pings to a halt if you have doubts. There is no escape from the bleep, not even in sleep.

How much easier life had been as a student. Having spent three months trotting across the globe in the name of medicine, we returned to Guy's in January with, in varying proportions, memories of bravery, tragedy and dysentery. As a student, the sky had always been blue and no-one's grass had been greener. However, there had always been a dark object, just the peripheries of vision, that I had not been able to define. It would occasionally come into focus, but never for long enough to identify it. In fact, it had been there for so long, I had grown accustomed to ignoring it. By February, it was impossible to ignore. It was huge and expanding, and it had a terrible word written across it—Finals.

Finals had always seemed so distant, and even then they were still four months, or sixteen weeks, or countless days away; but something had to be done. The first thing, of course, was to copy past examination papers—not to read them, but simply to possess them. Obviously, if one read them, it would only emphasise how little one knew. Second, one buys a book on every medical and surgical specialty so that when one starts to revise (or vise), there is the equivalent of four acres of rainforest on the shelf. Clearly, this is the entirely wrong strategy—what we should do is take histories and examine patients until the middle phalanx of one's right middle finger is sore from percussion, and then go home and read about the cases from the two or three books that you have read and re-read over the past years. We all know this is the effective way to learn, and everyone tells us so, but very few people actually do it. Instead, we wade through enormous tomes, memorising trivia and minutiae,

revelling in eponyms, so that we can disturb our colleagues by glancing anxiously at them when they cannot name the features of some bizarre syndrome we had read about the previous night.

The time between the elective and finals whistles by, but no matter how much work you have done, there is one thing of which you can be certain. On the morning of the first examination, when you all gather nervously outside the hall, you will all agree that you have done no work whatsoever until the previous night, and that even then, it was the wrong subject.

The examination timetable staggers on for about three weeks. The written papers are all held at the University Examination Halls, while the clinical exams are held in hospitals throughout London. There is a wide variation in the type of both patient and examiner at each hospital, and some have become legendary. If one is asked to attend St Thomas's for the examination in surgery, it is likely that you will meet more surgical pathology in the patient for the twenty-minute long case than you have seen in your entire time as a student. It seems remarkable that so many problems can exist in one human being, and one can only assume that they are at the bottom of a great many waiting lists.

For finals, one is obviously anxious, and in surgery there are only twenty minutes to fully clerk and examine the patient before the examiners swoop in for the kill. Clearly, what is needed is a succinct history of the problem and an examination of each system. However, at St Thomas's, when one enquires about the presenting complaint, the patient just smiles knowingly and asks which you would like to begin with. Once you have catalogues all the problems, there is usually about ten minutes remaining. Hurriedly, you examine the systems alluded to in the history, and hope to demonstrate the salient points. A quick listen to the chest reveals a cardiac murmur (and you congratulate yourself for finding something not mentioned in the history). As the patient then stands up for you to examine the inevitable hernia, you realise that he has not mentioned his varicose veins and false leg. The bell then rings, and the examiners enter and ask you what you saw in the optic fundi. As the inquisition proceeds, the examiners continue, with an accuracy that would have made William Tell blush, to hit upon successive topics about which one knows little. At this point, the female candidate will allow her voice to gently tremble and a small tear to well in the corner of her eye. This, of course, transforms the examiners from merciless ogres to playful, timid lambs. Consequently, as you lie shattered and trembling, she emerges clutching the examiner's handkerchief saying, 'They were so lovely'. Not that I am bitter, you understand.

The cases one might face in medicine vary widely. Whilst some candidates are guided through rooms filled with wailing children, other muse over videos

of psychiatric cases. Physicians tend to be friendlier that surgeons, and psychiatrists, in particular, are able to put one at ease—you will know the psychiatrist because he will be wearing brown shoes or a shiny suit.

However, one is not alone in the struggle to pass finals. Those people who generously agree to be examined by any number of trembling, sweaty hands are almost invariably a source of succour. I am sure that, if it were not for the help of these people who are able to recognise panic in the faces of others, a great many more students would stumble at the final hurdle.

The examinations seem to drag on forever, and it soon becomes impossible to revise between them. Gradually, the panic and anxiety give way to resignation, exhaustion and a yearning for it all to be over. Eventually, it ends, and there follows a period of about two weeks while the results are compiled. It is an agonising wait, during which one cannot help but muse over one's mistakes, an each night their significance is magnified until one is convinced that failure is inevitable.

The results are posted in the time-honoured fashion and, provided that one has passed, it is a time to look back and laugh.

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50 Years On

Wartime Rugby at Guy's

My school doctor had been a great athlete. A keen supporter of school XI and XV, he was notoriously over zealous in permitting the casualties of last week's match to turn out this week, before 100% recovery. But—as Mr Weller said—it was an amiable fault, and we liked him for it. He was delighted to know that I was going to do medicine. Though his pleasure was modified when I told him I was to enter Guy's; he was a London man. Honourable to the last, however, he admitted that I should get better rugger in SE1 and E1.

I already knew this, and arriving at Guy's in October 1938, looked forward, in the happy innocence (and arrogance) of youth, to adding lustre to the record of the club at HOP Retributive. Disillusion was not long arriving. I have no idea of the great gulf—physical and psychological—between good school and first class club rugby. Among the men, all but the most talented and mature youths could not long compete. I was given a game for Guy's—on the strength of school repute no doubt—and my baptism of fire was to war with the 'wizards' of Aberavon. 80 minutes of scrummage with the Welsh was educative, and chastening. Soon after, by decision of the selector—and with my whole-hearted concurrence—I became a member of the A XV for this last pre-war season.

The war brought major changes to rugby as a whole, as it did to the Hospital. Students, pre-clinical and clinical, were largely removed from Guy's, to become established, or transients, in parts of our Kentish sector. Dartford, Farnborough, Orpington, and Pembury hospitals all accommodated groups of Guy's staff and clinical students whilst the pre-clinicals spent four years at Tunbridge Wells. This meant very different sports arrangements for most—although fortunately HOP was not (as were some club grounds) taken over as an anti-aircraft site and/or for the growing of vegetables.

Two major decisions were made by the Rugby Union early on. First, official international fixtures were cancelled. Secondly, the apartheid between players of Union and League was suspended so that those of both codes could play together so long as what they played was the fifteen-a-side game.

As the sesquicentenary of Guy's Hospital RFC, is nearly upon us (and incidentally the centenary of the official opening of HOP), Gazette readers may be interested to hear more of those war years, of which the climax was for us the Centenary season of 1943-44. To set the historical scene. The first post-war

seasons, after 1919, had seen the greatest fifteens which ever wore Guy's colours. In the three seasons beginning 1921-22, we won 58 and lost 27 games of a fixture list as strong as any in the country.

For the seven seasons, either side of 1930, wins and losses more or less broke even. From 1934-35, to the second war, Guy's won 47 but lost 111 matches. Nevertheless, and as the reason, the fixtures were still as tough as could be. Clubs played in 1938-39 included Neath and Aberavon (twice); in the provinces, Coventry, Plymouth, Gloucester (twice), Bedford, and Birkenhead Park (twice); in London, Harlequins Rosslyn Park, Richmond and the London Welsh and Irish; and Cambridge University (twice)—but not Oxford. As the for and against points ratio was roughly 5:8, it can be seen that although more often losers than winners, there was never a rout.

The changes due to World War II were numerous. Some clubs closed down; those which played on became increasingly mixed. Players on leave—or posted near London—would get in touch with, and turn out for, any club which could give them a game. In completing such scratch teams, secretaries came to rely on calls to hospitals to make up numbers. I recall going with Guy's friends to sport the colours of Rosslyn Park and Wasps on several occasions. Here, one met, and played alongside, others from the greatest to the less-so, including 'professionals' from the League. One itinerant scratch side was more-or-less launched by the War years, and still lives on, the Public School Wanderers. Organised, accompanied, and exhorted by a journalist, the late Charles Burton, the team contained players from all schools and several counties. We had a lot of fun.

Travelling by the public was officially discouraged. 'Is your journey really necessary ?' was a ubiquitous question on station hoardings. And, if one travelled despite this, trains were infrequent, crowded, and slow stoppers. Petrol, of course, was strictly rationed.

Having, of necessity, to give up their far-flung historic fixtures, London Clubs made up the deficit by the creation of some powerful adhoc fifteens. Some were occasional combinations. For example, Guy's played both a Richmond and Blackheath XV (1941), and combined Celts (London Welsh and Irish)(1940). Most formidable perhaps, were the teams of the Forces: Welsh Guards and London District, the New Zealand Army and RNZAF (usually peppered with All Blacks), and the R Australian AF. Both Aldershot and Portsmouth Services were within reach, and with Bedford and Cambridge & Oxford Universities represented the limit of possible away games. Indeed, because of the fine facilities at HOP, these years Guy's were much more often 'at home' than visiting. In five war-time seasons, Guy's record was home 92, away 54. Results were marginally in favour, won 74, lost 69, drawn 3, points

for 1359, against 1271.

The most welcome bonus of hospital rugby in 1939-45 was the playing of many non-cup tie matches between the London hospitals. The annual Hospitals' Cup Competition was suspended for the duration and replaced by a seven-a-side tournament, usually in April—and usually won by St Mary's.

But during the season the hospital sides met, as they chose, on a 'friendly' basis. Indeed it was so. As the unknown reporter of Guy's v The London match wrote in the Gazette, 'Wartime has given the hospitals a wonderful opportunity of meeting in friendly rivalry in an atmosphere entirely different from the Cup matches.' I am sure that all of us who played in these fixtures would endorse this whole-heartedly. Indeed, it is to me, a great pity that the resumption of the Cup ties in 1946 led to the discontinuance of the friendly games; hard, but not desperate do-or-die affairs, and memorable in the après match conviviality.

Overall, Guy's played 43 such inter-hospital matches, winning 26, losing 14, with three drawn. The longest series was (naturally) against St Mary's, 10 matches, of which we won only three. But two of these victories were in one season (1941-42)—an annus mirabilis. The win at HOP, was a nail-biter. All but five of the other inter-hospital fixtures were played against Bart's (7), St Thomas's (6), and the Middlesex (7). Guy's 'won' each series in aggregate—wins 17, lost 7, drawn 2.

I began by telling of my failure to carry all before me in 1938. Happily for me, the combination of vacancies created by departures for military service, and my facility for place kicking, gave me one full season representing Guy's—doubly so, as this was 1943-44, the year of the Centenary.

Celebrations in wartime were, of necessity, limited but some special fixtures were played. As a pipe-opener we dispatched a 'Past & Present' side fairly readily. Having then beaten Middlesex, Bart's and Thomas's successively in October 1943, we came down to earth with a bump, losing heavily to Mary's in mid-November. Next week, there followed, the Centenary Match, against London R U, at HOP. Hardly spectacular, though we were, as the neutral *Daily Telegraph* reported, 'unlucky to lose' by a last minute try. There followed an HOP dinner with speeches from a large number of elder brethren and VIPs. Fatigue and beer have left me no trace of what was said—but I am sure it was splendid and complimentary. Then, a different thrill, a journey to Tom Brown's Bid Side to play Rugby School 'Past & Present'—and to read the stone in the wall describing William Webb Ellis's creative act of rebellion. Guy's won by 12 points to six. Having won eight of 13 matches in 1943, we slipped a bit after the New Year, losing 10 of the remaining 13 fixtures. But to lose twice, for example to the RNZAF, by 11 to 13 and eight to nine, was no disgrace. And,

Guy's did beat a scratch Oxford & Cambridge XV, by 25 points to 11.

I cannot speak at first-hand of the last wartime season 1944-45. The record certainly is not one of our best (won 3, lost 16, drawn 2), but even so, St Mary's were beaten (10-0), a memory which the surviving participants will, no doubt, still savour.

Two unrelated medical incidents of the centenary season remain in my memory. In darkest January 1943, we made the short trip to Hale End to play The London. It was a miserably wet day. The referee was middle-aged. Most of them were by that stage of the war—enthusiasm outrunning discretion on this occasion. For, early in the game, the unfortunate official wheezed, coughed and produced a small haemoptysis. No lack of would-be medical advisors of course. But as London were on their own ground, we surrendered any claim to clinical oversight, and the patient was taken to the Whitechapel Road. There was but one touchline spectator, but luckily he was, even if older than the referee we had lost, a one-time referee, an ex-metropolitan policeman who did a bit of reporting for the Sunday papers. So he put away his notebook, donned borrowed boots and whistle, and finished the game, being suitably thanked in the bar afterwards. Guy's won.

In the same month, we made our annual visit to the Bedford Club. Here, we were usually beaten; this time was no exception. Maybe non-success was related to the (then) considerable slope on the Goldrington Road ground perhaps more to the hospitality of the Club Committee. For it was their kind habit to give visitors lunch at the Swan Hotel. A good lunch in wartime was not to be sneezed at, and I fear that, despite a collective desire to win the game, the spirit may have, to some degree, surrendered to the flesh. During out 11—14 defeat, our full-back G A 'Peter' Hildick-Smith, a fine all-round athlete, was badly concussed.

He should, of course, have been warded at Bedford, but naturally insisted on getting 'home' to Guy's for treatment. In the train he began to take less and less interest in things; causing worried consultations on what, if anything, could (should) be done during a journey for subdural haematoma. However, Peter was still conscious, if dopey, when St Pancras was reached. At the barrier, a constable suspiciously viewed this shambling figure, who we supported, with difficulty. 'It's alright officer,' which was hardly the case, 'He's had a knock on the head.' He did not look as if he believed it for a moment. True, there was a smell of beer in the air. He growled,

'You'd better get him to bed sharpish then.' And, this we did, where he stayed for a week, remembering nothing after the splendid lunch by the Ouse.

To bring this ramble to an end there are one or two things else to say. Mention of some persons and not others is a delicate job. Yet I'm sure that all

Guy's rugger supervisors of those seasons will not quarrel if I pick out two.

George Winston the Wills Librarian was for years the rugger club's fixture secretary. Before the war, even with several sides the task was, I expect, fairly straightforward. But when all or most of the regular fixtures went of for a Burton, he faced and conquered a challenge indeed. Over and above that he became the 'agent' or contact man for the player exchange that I mentioned earlier. One went to his office and as often as not emerged to set of for an enjoyable match with a scratch side or a club which was a bit short of servicemen on leave. One of my most pleasant memories is the making of a 'seven' with another form Guy's, three from Bart's and two from the Middlesex. And we got to the semi-final of he tournament. George Winston must have been the deus ex machina for many who sought some exercise in those years.

In his history of the Club's first years (Gazette 1968), T L T Lewis records the names of 33 Guy's men who had then attained international status, either for the four home countries or for South Africa. As the outstanding player of 1939-45 I would like to recall one who is not on that list—but only because of the War and his tragically early death—M R (Mike) Mullins. Those who knew him need no sketch from me. Those who never had such good fortune I refer to his obituary (Gazette 1945 p 27). A South African, he came to Guy's from Oxford in 1939 and captained the Club in 1942-43. At the end of the season, although he would have denied it modestly, he led Guy's to victory over St Mary's by singlehandedly blotting out Mary's famous international fly-half, Tommy Kemp. The obituarist (the late Sam Wass), amid much else, refers to Mike's, 'unfailing cheeriness and sportsmanship...and an inspiring leader.' His death on active service in Italy robbed many of a true friend and the post-war Springboks of a great wing forward.

David Gullick

Guy's
Hospital
RFC

150th Season
Festival Day

Honor Oak Park

On the perversity of inanimate objects

By James Pitt-Payne

There is a law somewhere which has a name, and states that: Any given object will, for reasons that are either totally obscure or completely mysterious, of its own volition, etc, act in a manner that is totally unexpected, and in a way unfavourable to members of the human race. Over my years as a GP, I have collected many such cases, and I thought that I might share them with my reader. Circumstances have always altered cases, but there is another factor first notated by C G Jung, the great Swiss psychiatrist and psychotherapist, who called it 'synchronicity', and tried for the scientific explanation which is being further evaluated by ardent chaologists today. I have a mistake, which I make repeatedly, in that at a party I may go up to a particularly buxom and bonny-looking woman and ask her when her baby is due! On being met with that blank stare I know so well, I retreat to the other side of the room, or better still, another room where I quietly disembowel myself with my metaphorical kukri. 'Pitt-Payne's kukri classes,' I should call them.

Tactlessness

The uncalled-for remark is another specialty of mine, as may be evinced from a case which came to me one New Year's Eve many years ago. The woman was complaining that her recently inserted coil was about to drop out. When I came to it, the strings were a shade too long, and it was the work of a moment to cut them a bit shorter, so that she would not be annoyed by them during her various festivities. At the end of this little exercise, I felt quite pleased with myself, and offered her the season's greetings, winding up as I did with a bit of a flourish, '... and now you'll be able to see the New Year in with a bang, and not a whimper.' I don't think she was too amused—funnily enough I never saw her again, but it was yet another blow struck on behalf of the Bromley & District Gynaecologists.

And tactfulness

On another occasion, I had to keep quiet. My bathroom scales resided in my

surgery, and they had been doing very well indeed until a Miss Evans stood upon them. She was a short, somewhat mesomorphic type, light on her feet, stolid in her attitude, cheerful in a glum sort of way; hardly a barrel of laughs, but a barrel nonetheless. I should have taken the hint when my BP cuff failed to go round her arm, and we had to tie it on with bits of string, etc. The reading I got was a joke—as was the weigh-in. The bathroom scales had been a wedding present, and they should have stayed in the bathroom. When Miss Evans stood on the scales, the dial spun round with alarming speed, and before I could do anything about it, there was a dull ping, a terminal mechanical groan, and the dial was stuck at 5st 12lbs. 'That's just fine!' I breezed, 'You can get off now.' She did, but the dial stayed as it was, thus immortalising the awful truth about Miss Evans.

I do not like to argue with my patients. It is always pointless, and so much easier to agree with them, even if what they say does not accord with my panoramic view of things out there. One very determined 'old-thing', though, was quite bent on having a go at me, and my Waterloo was to be on the matter of a Seat Belt Exemption Certificate. When seat belts became compulsory, it was quite extraordinary the way various complaints came sidling out of the woodwork to make themselves known to me. A typical example of this is the patient who, on knowing that he may be imprisoned for a crime, informs me that he suffers from claustrophobia and cannot bear the thought of being locked up. Experience has taught me that the slightest hint of this as a disease process will almost certainly make the judge send them to gaol, even if they are only on their way to the nearest open prison facility.

'I distinctly heard you say it, doc. Back in the Summer, you said you'd give me a chit to say I needn't wear one.'

'I have no recollection.' I admitted, shaking by bonce.

'My memory is far better than yours doc. I remember you saying it.'

She was an old lady, if what is left of my memory serves me right, and I had the distinct feeling that she was looking for the excuse to give up driving, thereby using me as the scapegoat in the process. I was on my way to a hiding to nothing. She said that if she wore anything like that it made her claustrophobia bad. I had attended her for years, and this was the first mention of such a thing. What to do? That was the question.

In the event, I gave in, of course, as I have always tended to, and the incident was closed, but for one very interesting thing—she never drove her car again.

The number of times I have nearly nodded off as I listen to a patient-speak monologue. The first time it happens, one laughs; the second and subsequent occasions the grin becomes fixed as I find my physiognomy assuming a Madam-Tussaud-like countenance.

'And there was my Billy, doctor. 'E was born covered in oil ...' She had a odd way of pronouncing the word 'oil. ' ... anyway, 'e just sort of slipped out, and I could 'ave sworn it was all that liquid paraffin oil, Doc, Ainslie gave me when I wos carryin' 'im. What d'you think, doctor ?'

By this time, I am miles away, fishing off some bank at a reservoir in Kent somewhere.

' ... mmm?' I come to suddenly. 'Oh, yes, yes indeed!' I nod my head firmly.

'You look tired, doctor. You're not gettin' enough sleep.'

I smile wearily. It would be a pity to spoil her view of me. 'I can't see how on earth liquid paraffin could cross the trans-placental thingummy-push-ah-um-well, I can't see how it could.' I wind up lamely.

"E wos covered, and I tell you no lie.'

'Quite extraordinary ...' I murmur, encouragingly, I trust. Dashed closed thing that. I nearly nodded off.

No way out

There are many laughs to be had with the elderly. In fact, I think I prefer them most of all because when they play a joke, it is always a bonus. There was one such woman, who, in her childhood, it was rumoured, had met Rasputin whilst in Russia in the halcyon (for some) days before 1917 and all that.

'Ah, young man. It's my birthday! You may kiss me.'

The command came from an enormously well-upholstered old lady, the nearest thing to a well-stuffed Chesterfield sofa I had ever seen.

'How many is it now?' I enquired, having safely negotiated the osculatory gesture without being struck by lightening or the considerable static electricity she must have incurred whenever her stocking-tops rubbed together, which they did like well-healed cicadas as she walked.

'Eighty-five,' she replied without batting an eyelid.

Time would reveal her true age after she was gone, and her estimate was way out. However, it really did not matter. At the next house there was no such celebration.

'You could have wiped the lipstick off your face before you came,' said a mildly disapproving voice.

'Eh?' I glanced swiftly in a mirror. Sure enough, I had been so daubed. In retrospect, I can only laugh. So many of these old folks are just full of silent mischief.

And then, there was a film star. Well, she had been a film star, but she had been a bit of a pin-up as far as I was concerned when I was a lad. It was when I began to mention the past that I knew I had played the wrong card.

'Yes, I remember you, when I was a boy,' I prattled away happily as I began to take her blood pressure, '... when you were in that film with Yul what's-'is-name and Tony Curtis, and there was this big heap of logs and ...'

'Yes, my Hollywood days,' came the tight-lipped reply.

She never did pay my bill, of course. Film stars are such lousy payers, but after twenty minutes of me, I reckon I got my moneysworth.

It is a very finely balanced thing, this doctor-patient relationship, and never is it better tested than in the intimate situations we are prone to find ourselves. We male doctors have been discussing the benefits and disadvantages of chaperons for years, whereas our female colleagues seem to have been able to manage without them. There was an especially splendid woman I saw once, and it became inevitable that some kind of examination would be necessary. Women would understand this, of course, and see it all as part of a doctor's day, but we are human too, and but flesh and blood. A fact of life all too often forgotten by our general public. The thing that placed this woman head and shoulders above the rest was the comment she made as the 'chaperon' walked into the surgery.

'Is this for my protection—or yours?'

It was an imperiously-put question, with just the right amount of mischief, and I was suitably tongue-tied, realising that I was in a 'no-win' situation, where to have made any kind of reply would have been to insinuate all manner of unconscious suggestions. Since then, I have been prepared with a suitable answer, which is not for printing here.

On the perversity of inanimate objects...

All this is a far cry from the inanimate objects which I have said so little about. The first object is an aluminium ladder, one of those ladders that hold even the most unbalanced of individuals whilst they potter about the house doing things. One such ladder was in the garden resting against a tree whilst my patient lopped away happily at the branches of some fruit tree. Suddenly, a spot of metal fatigue set in, and the poor woman was thrown to the ground and her bottom was bruised. She was none the worse for her experience, but the ladder had to be destroyed and thrown away. Another ladder threw my patient out of his apple tree, and he landed up in hospital with a fractured femur.

Tins are notoriously bad performers. Remember that famous threat from Harry Seagoon in the 'Goon Show'? : One step closer, and I'll turn the key in this tin of spam. A humorous threat, of course, but how many of us have been cut by tins as we try to open them? Corned beef, pilchards, anchovies, sardines in oil or tomato sauce, and, finally, the ubiquitous spam. These wounds are,

indeed, grievous once they have been inflicted, but not before.

There was an aluminium garden chair once, the type with a canvas seat and back, and arm rests. Solid enough until a nineteen-stone woman with a low centre of gravity came to rest upon it; whereupon, and notwithstanding, it did fold its arms about her, and sank to the ground clasping her in its metallic grip. The Fire Brigade had to be summoned, and the chair was destroyed so that my patient might be saved—and she lived to a great age. Her end came, as I remember, on a commode—a truly magnificent thunderbox, it was, all in mahogany, more capable of supporting her as she was swept into the Great Blue Yonder.

Lastly, I come to Sidney, and I have saved him until the end because he tempts providence at almost every level of his existence. He tends to sleep rather badly from time-to-time, and he is a martyr to his rheumatism. Only recently, he awoke in the night, at 3am, and decided that he would be needing a hot water bottle to ease his aching knees. Accordingly, he donned his dressing gown and slippers and made his way along the landing, and then down the stairs. In a moment of staggeringly bad luck, he lost his footing three steps from the bottom—either that, or one of the aforesaid knees gave way, and he crashed head-first into a very large china swan at the bottom of the stairs. The said artefact was filled with something he alluded to as 'potpourri'. The swan was smashed to bits, and there was potpourri everywhere. I saw him later the same day, and listened intently to his tale. His wife, he said, had been very displeased with him as she had had a special attachment to this giant porcelain bird.

'Have you smashed any other bits of crockery ?' I ventured, sensing that here might be a man with a bit of a tale to tell.

'It's funny you should say that, doctor ...' he began, and thereby unfolded a tale of carnage on almost the grand scale as to the various ornaments he had collided with in his home. Heads had been knocked off large-scale tigers, a dog's tail had gone in another incident, and various bits and pieces had correctly obeyed the laws of gravity in their downward path towards the floor.

James Pitt-Payne

Doctor Schueler's Home Medical Adviser

Doctor Schueler's Home Medical Adviser is the modern equivalent of the Home Doctor Manual which used to be on the bookshelves of all self-respecting homes 40-50 years ago. It is now on disk, and instead of flicking through the pages looking for an interesting complaint to take to your doctor, you can now use your mouse to take you through the windows.

After the initial disclaimer the Home Medical Adviser presents you with a picture of a rather fit looking man viewed from the front back and head only. With a flick of your mouse you can change him into a female who looks as if she has been overdoing her weight training. You can choose a particular part of the body to explore the symptoms or go into the disease file if you think you know what is wrong with you. Other files cover drugs, injuries, poisons, health and disease.

I am not sure that patients would find it worth starting up the programme for one particular symptom. It seems to be more appropriate for those looking for an interesting symptom or disease to take to their next cocktail party. Alternatively, you could use it to check up on the advice from your doctor. The current version lacks a section on how to sue your doctor for anything he didn't tell you however. There is a search facility if you only remember part of a condition you were told about. I tried 'war' and came up with warts, warfarin and some other drug.

Although the programme is quite wide ranging it does not go into enough detail on individual conditions to be really useful. The format could be adapted for a medical audience but, apart from the section on drugs, the information would need to be very much greater; unless the graphics were more extensive and of better quality it would have little to offer over a book. It might work better for information on drugs, where cross linking of information could make the facilities of a computer more useful.

I have not come across general medical programmes on the same lines which are worthwhile but I am sure that they are on their way. Meanwhile, I am going back to Dr Schueler to see what he has to say about this pain in my knee...

Dr J Rees

A review of the year

The United Clubs is the student representative body within UMDS. I took over the presidency from Bill Francis—a hard act to follow, on the first of February this year. This is the last time there will be a shared UMDS presidency. Smokey, the newly elected successor, will be the first of the new committee presidents.

Although I officially took over the

presidency from Bill, our roles did not really change, and we carried on working together. When we started our year in office all of the new committee were filled with high hopes and enthusiasm for the jobs ahead. This enthusiasm hardly waned all year. I think the chief aim of Bill and myself was to bring Guy's and St Thomas's students closer together and to make the most of the facilities that can be found on each campus.

It has become clear that the government has got the knives out for many of the great London Teaching Hospitals. However, as students of UMDS, we are a part of a new medical school and hospital trust that seem to have a very secure future. But this future must be as one single institution. This opinion has led to many heated discussions within United Clubs and the other student clubs whom we represent. There were some people who held the opinion that one hospital was better than the other, and that uniting sports clubs and students would detract from the history and tradition of individual clubs. Loyalty is commendable, but we must move forward and realise that we are students of UMDS at the Guy's and St Thomas's Hospital Trust. Our survival and prosperity can only be ensured by unity. This will produce a powerful student body with a complete sense of history, healing the rift between the two great hospitals and medical schools which started several hundred years ago.

Freshers Week

The year started off well. The new intake promised to be very active and involved Freshers, with all of the events well attended and everyone enjoying themselves. More than a few new friends were made...

The first term was a hive of social activity with the Thursday 'alternative nights' at St Thomas's bar complementing the normal Friday Hop at Guy's bar. The Halloween ball was a great success, everyone enjoying the unusual venue and the bargain price, except for Mike Fendick (who has done a sterling job all year), Jon Spencer and Lorraine Foley (student treasurer) who made sure that the sometimes extravagant spending was controlled.

The highlight of the first term for many people was the now infamous Christmas Show. The event was staged, as usual, at st Thomas's bar and contained the usual amount of stolen ideas, songs and exposure, topped off by the first appearance of those monsters of sex, those passionate seekers of pleasure, the Dancing Boys—beer bellies and all.

Term two

The second term saw the opening of the newly refurbished St Thomas's bar, thanks to the hard work of Anne Ward and co, with its lovely brass chandeliers. This term, traditionally a quiet time, saw an explosion of drama mid-term, with the rugby club getting knocked out of the UH cup by the eventual winners CXWMS. Unfortunately the drama on the field was overshadowed by the behaviour of the drunken Guy's supporters off the field. Also in the second term an idea was being discussed about alternating Friday hops between campuses. This was the subject of some wildly inaccurate rumours and the fuss made led to the idea being dropped before it could ever properly be discussed. The end of the second term saw the return of the medics from Lille, our twin medical school in France, for a weekend of sport, beer, and patriotism.

Unfortunately Mr Argles and Prof Chantler left the Friday dinner before they could witness some spectacular vomiting by certain UMDS students which totally put our friends to shame. On the sporting side the French managed to win the football at HOP on Saturday 1-0, but an impressive display by the UMDS 1st XV on Sunday at Cobham soon set the record straight with a 53-5 victory in the rugby.

The summer term

The highlights of the summer term are always the Bumps, Rag Week and the Summer Ball. Chris Davies and his merry band did a superb job in Rag Week and despite numerous setbacks during the week managed to raise approximately £28 000. The Bumps were held on the eve of the final act of amalgamation of the boat clubs and proved to be very enjoyable. The high point was the last night party.

Thanks to the hard work of Edward Hughes and Lorraine, the Summer Ball proved to be a fitting end to our year; their organisation, along with everyone's help, produced an exciting ball with very high quality entertainment. An all round wonderful evening was had by all. The only thing spoiling the event was the lack of students—they don't know what they're missing. Finally one of the most important changes for United Clubs was the ratification of the new United Clubs Constitution. The AGM held in May proved to be very popular, and it was good to see so many people actually taking an interest in the running of their student union.

Richard Probert
Student President

Nora Relihan

Sister Relihan's retirement must mark the end of one of the longest serving records for a nurse at Guy's. When she joined Guy's in 1942, nurses were paid about £30.00 per year, worked very long hours, and had one day off a week, which was forfeited if the nurse had overslept any morning when she should have been on duty.

'Reli', as she is popularly known, came from Blarney—where you can kiss the stone—County Cork. Her entry into nursing was via Moorfields Hospital in 1940. Coming to Guy's in 1942, in the middle of the war, she spent much of her training at Farnborough and Orpington hospitals. The matron at that time was Emily MacManus—well-known author of the book, 'Matron of Guy's'. The tutors in the school of nursing at that time were all well educated women, prominent in the profession, writers of nursing textbooks: Hilda Gration, Florence Taylor and Dorothy Holland.

After the war, Reli became a staff nurse of the old eye ward on the ground floor of Hunt's House—Ruth and Barnabas. On being promoted to sister in 1947, she spent a period on night duty and in the school. Soon, she became sister of Ruth and Barnabas, having forty-two beds under her responsibility, until these wards were divided into separate care, and Reli looked after the twenty-four beds in Barnabas plus the eye theatre.

I first met Reli in the early 1960s, when she was Sister Barnabas as, apart from the ophthalmic cases, there were two beds allocated for VD patients. The VD patients under her care were either syphilic cases with tabes dorsalis, or rheumatic patients with Reiter's syndrome. In her early days cataract operations were followed by a near motionless stay in bed for ten days, compared with the one day stopover nowadays. This has meant great change for nursing.

Sadly, since Reli's time on Barnabas, the eye theatres have gone over to St. Thomas's—an early merge—and on closure of Barnabas, Reli was sister of Ester in New Guy's House from 1974-81, when she retired from her full-time post. Since then, she has worked part-time, two days a week, as nurse/technician in the Neurology Department, situated on the site of her old wards of Ruth and Barnabas.

Reli was very happy in her long time at Guy's, and her sadness at leaving is tempered by the changes which are taking place that are not altogether to her taste.

I asked her for her thoughts about the future at Guy's; she naturally hopes it will stay on its present site. Indeed, she has been promised that a ward or department in Philip Harris House will be named Relihan in her honour. However, the prospect for this is in the future. She would prefer to see Virginia Bottomley return to social work!

Of nursing, she is worried. Recognising that there must be change, she wonders whether the new nurse training, under Project 2000, will mean that students will have little experience at the bedside. 'Who will train the learners

Sister Relihan

then?' she asked. Reli thinks the Royal College of Nursing has become, 'A bit dull,' since Trevor Clay, one of the first male nurses at Guy's, retired. Perhaps this is a surprise to some readers, as male nurses were not seen at Guy's during Reli's training, only appearing at Guy's from about 1960. Reli recalled visiting Mexico for an international nurses' congress, which was the largest assembly of women she had ever seen, and a bit boring in consequence. So, the change to employing male nurses is one she approves of.

When Reli trained, and for many years when she was a sister, the use of first names amongst staff on duty was quite unheard of. Discipline was strict; nursing the better for it. On one occasion, when a student, she let a serviette slip from under a patient's chin during feeding. Matron was doing her 'round', spotted this, and tore her off a strip. When she became a sister she ensured all her nurses received a good, practical bedside training.

Reli is a Roman Catholic, and goes to church, but does not see nursing as a vocation. When she started, coming like many other girls from Ireland, there was little choice of occupation for women there. Entry to teaching or the civil service, two other careers, was less easy, and thus nursing was the only plentiful alternative available. She has not regretted this, however, and loved nursing tight from the day she commenced. She believes some changes in nursing have occurred as a result of shorter working hours. This means that nurses have less time with their patients, and thus cannot identify so thoroughly with them during their stay in hospital. Also, many nurses are married; they have a dual role to play. When Reli began, all nurses 'lived in', and marriage meant leaving the profession. She has never married, 'No-one ever asked me.' she quipped. An addition she would have enjoyed, would have been a combination of secretarial tasks with nursing, or to have become a GP's practice nurse,'..a very nice job.'

Last Autumn, a party was held to celebrate Nora Relihan's fifty years at Guy's. One gift she received was an out of print work by Wilks and Bettany's, published in 1892, 'A Biographical History of Guy's Hospital'. This obviously gave her great pleasure. When I was talking to Reli, to gain a few facts for this appreciation, she finally said, 'Now, I want to blow my own trumpet.' She said that during all the years, over half a century of nursing, she has never had a day off sick. If she went off sick, she claimed, the onus was placed on colleagues, and patients suffered. I said to her that she must have a strong constitution, and been lucky. Surely this is a record? I suggested she should be honoured. She replied, 'I did receive the Jubilee Medal.'

She is now retiring because she wants to, and she has the opportunity of a home of her own, near family, back in Blarney. I am sure I speak on behalf of all her friends and colleagues here at Guy's, past and present, in wishing her a long and healthy retirement, time to put her feet up, and the chance to kiss that stone again. Reli asked me to include her new address: 13 Chalwood, Blarney, County Cork, Eire.

Denis Cobell

Rugby—1st XV season report

Played 31. Won 19. Drawn 1. Lost 11. For 795. Against 329.

After a poor start to the season (and following intensive training with our new coach), by mid-October the 1st XV started to string together the kind of results that we always knew we were capable of. Old Walcountians 45-11 and Alton 22-20 were two vital wins in the league, having lost our first three games.

The improvement continued upto and after Christmas, with victories against Winchester, Blackheath III 48-22, Shirley Wanderers 62-3 and Askeans 62-10. In the Hospital's Cup we narrowly lost, 9-13, to Charing Cross and Westminister who went on to end Mary's seven year winning streak in the final. Surely our time will finally come next year.

Late season wins against Old Reigatians and Warlingham both summed up the tremendous team spirit of the whole club. This season we were very fortunate to have a good intake of players of all shapes and sizes and of varying rugby talents, all of whom played with true Guy's spirit.

This season has seen the development of a strong playing squad under the eyes of Nigel Baker, and the trials and tribulations off the field have seen the spirit of camaraderie and friendship, for which the club is famous, unite us together even more strongly. I'm sure that next season this will ensure success for the Club and all its supporters. I wish Ed Barrio every success for the coming season and that all the players and supporters have an enjoyable season.

Roy Cunnington

Rugby—2nd XV season report

Played 24. Won 14. Lost 9. Drew 1.

The Seconds had one of their most memorable seasons in recent years, regularly fielding a strong Saturday side and then bringing the 'A' team Hospital's Cup back to Guy's after 20 years absence.

We played 21 Saturday fixtures with some hard fought and memorable wins, especially against London Irish XV (won 26-25) and Stretham and Croydon II XV (won 16-15). However, without a doubt, the most exciting and toughest matches were our spirited performances in the Hospital's Cup against St Mary's (won 13-11) and Charing Cross and Westminister (won 17-10) in the final—giving Guy's Hospital RFC one of the prizes it so deserves.

I would like to thank all the players in the seconds for their commitment during the season and wish John Murphy the best of luck for next year.

Jon Spencer

Rugby—3rd XV season report

Played 22.Won 15. Lost 7. For 492. Against 355.

The Thirds had a very enjoyable and not unsuccessful season as the figures show. Our opposition was a mixture of the usual legue third XVs and new fixtures against sides the team has not traditionally faced. Our success against league oppositions was without blemish, showing just how improved the

standards of rugby in the Thirds is from previous seasons and indeed throughout the club.

Notable victories were against Bec Old Boys (won 75-0), Old Emmanuel (won 44-7) and Meadhurst (won 13-3)—memorable for a spirited performance against a larger and better drilled first XV.

The Thirds also undertook a successful tour to Cornwall playing two games against Redruth and Truro. The tour party was particularly youthful, with notable absences of seasoned third team tourists (Kolin White excepted). This however was to prove by no means a disadvantage, and in the first game a memorable win was recorded against a considerably older and larger opposition, followed by a memorable evening. The game the following morning was not played with quite the same enthusiasm, with the exception of Christian Smith who seemed completely unaffected by the previous evening's hospitality.

The team's highest point scorer was Kier Lewis, a recent find from Harry's Fifths. The highest try scorer was Tom Nester-Smith, another new member of the club. The Thirds showed great spirit and enthusiasm, not to mention skill. It was an honour and pleasure to captain such a fine side and I await the 1993-94 150th season avidly.

Simon Russell

Rugby—5th XV season report

Played 16. Won 3. Lost 13.

The following report comprises some highlights of the season:

Guy's 5th XV v Old Walcountians V. 24th October 1992.

After a little adventure, getting lost in darkest Surrey, we managed to find Old OWs and the match started on the dot of 3 o'clock. This was our first game since the sad events of the 16th October, and so was the most difficult of all the fixtures we had. However, everyone was determined to carry on as best as possible and the game did become enjoyable as the game progressed.

A torrential downpour in the second half lowered our temperatures markedly, and brought with it a lot of cramps and other problems. It did not stop Ugo Ekeowa scoring one of his excellent tries.

I would like to thank all those men who made financial sacrifices, altered their plans for the weekend and travelled hundred of miles, from as far afield as Leeds and Salisbury, just to play this particular game. My thanks also to the 'new boys' that joined us on this day.

The score, lost 38-12. Guy's hospital RFC 5th XV business as usual.

Guy's 5th XV v Mitcham 4th XV. 12th December 1992.

Our first win of the season, before Christmas, and at home—what more could one ask for? There were of course the usual delays, but eventually we got started and the game was evenly matched for the first 20 minutes or so. Then Andy Pollock scored an unconverted try. In the second half we had a number of problems with crowd control. There were two pitch invasions by Prof Challacombe's dogs—one can't knock their understandable enthusiasm. Mitcham did make a determined effort to get back at us with their own unconverted try, but 10 minutes later Pollock scored another

try and put paid to their efforts. A singularly enjoyable game. The score, won 10-5.

Guy's 5th XV v Dartfordians. 13th February 1993.

Due to coach booking problems we arrived at the ground 90 minutes before the kick-off and used the time to mentally prepare ourselves for the match. Translation: we traipsed over the road to a hotel for drinks. We got onto the pitch 20 minutes before kick-off, something unheard of for the 5ths, stretched, warmed up and by kick-off time we were as ready for the game as we could ever be.

And it worked. We won by a clear margin. The try scorers were Chris Elsom and Andy Pollock—two apiece, all unconverted. We also scored a penalty. Final score, won 18-10.

Some scoffed at my theory that our early arrival and use of the time was the main factor in winning the game but I'm sure that it was.

Guy's 5th XV v Mitcham 4ths. 6th March 1993.

A particularly satisfying game, not only because we won, but also because the opposing team contained three members of Guy's second XV, namely Jamie Coombs, Pete Davis and Ed Hughes, who gained their only points out of our sheer generosity when we gave them a penalty. Mitcham are great fun to play against, but do get a little tense when loosing.

A good time was had by all.

Harry Evans

Rifle club

After a successful Fresher's Fair we recruited more names than ever before. During several introductory sessions the more experienced members taught the basics of .22 rifle shooting to our Freshers, the vast majority of whom were new to the sport. After several weeks a hard core of crackshots (and Tom Witcher) were ready for their first mission! A friendly match against a novice team from the London Hospital resulted in the Southerners beating the Eastenders. Our season was looking on target.

Several weeks of practice was interrupted by a fun 'Halloween shoot'. Targets included lighted candles, clay discs and a sweepstake was arranged for the most creative (and recognisable) pumpkin face shot into paper—Lethal Weapon style!

In November we embarked on our Rifle Club Tour, a joint expedition organised with the London Hospital. Our first stop was Cambridge University. Unfortunately their supposed B-team contained several recognised A-team and Varsity shooters. Their cool, calculating precision proved far superior to our own inexperienced and somewhat overawed young squad. A thoroughly beaten team had more success in Cat's Bar! The following day a rejuvenated UMDS took Loughborough by storm, beating their A-team by 751 points to 744. The nerves had settled.

For our final match we drove back South to Oxford to duel with their B-team. A tense final round resulted in UMDS beating the Oxford team by 1 point (out of 800) with the London Hospital trailing in last place. The enjoyment and success of the tour should be a trigger

for further future outings.

The smallbore season continued with UMDS winning the Lord Wakefield Cup (beating UCL, Birmingham and Loughborough in the process) and culminated in the UMDS A-team winning the London University Intercollegiate League. This was our first victory in this large competition, and the team consisted of:

Kier Lewis
John Lengyel
Sajid Khan
Chris Davies

Individual successes included:

KLewis- Runner up- Div 1 (avg. 98.8)
S Khan- 3rd place- Div 2 (avg. 94.8)
J Lengyel- Runner up- Div 3 (avg. 93.1)
T Witcher- Winner- Div 4 (avg. 91.0)
S Nair- Runner up- Div 6 (avg. 89.9)

Kier Lewis has also represented English Universities this year.

Many thanks also to Daniel Perkin for taking over as treasurer with short notice, and for helping a great deal with organisation.

Our fullbore season is well underway and we have entered three teams for the UH Cup at Bisley on July 16th.

We would gladly welcome any new members—all training and equipment is provided. If you would like to join one of UMDS's fastest growing clubs please contact next year's captain, Simon Hughes, via the rifle club pigeon-hole at Boland House.

Kier Lewis
Secretary

The rifle club

Priory cup squash v Eltham

The return match between the Thomas Guy club and Eltham took place at Guy's, with Guy's anxious to improve the earlier 3-2 win achieved at Eltham. With a strong team consisting of Cyrus Nikhah, Peter Goodyear, Ray Sharpe, Simon Charlesworth and Glynne Robinson it seemed likely that it would be avhieved.

Cyrus won well at No. 1 beating his opponent 3-0. Peter, unaccustomed to playing at No. 2, had a storming game and thrashed his opponent 9-1, 9-0, 9-0. Simon at No.3 won 3-0 playing his usual running game. Ray at No. 4 met an old badminton opponent and together they gave a wonderful, entertaining display. Ray had a close moment at 2-0 up and 8-2 down, but rallied well to win the set 10-8 to win 3-0 overall. Glynne, struggling valiantly with injury, put up a brave performance but lost 3-0. 4-1 to UMDS.

The team this season has been doing reasonably well and would have done much better were it not for injuries, illnesses and absences early in the season.

Peter Goodyear

New doctors

The following students qualified MB BS (London) in June 1993:

Ahsan Miss S
Ambler J J S
Anjarwalla N
Assadourian R
Auckland Miss C
Ball J A S
Behr E R /
Bessey Miss D E
Bowen Miss J M $
Briggs Miss J A
Bruce R C H
Buchanan G N
Bull Miss B I
Burt Miss C G
Byrne P R
Cade Miss H J
Carman Miss S J $
Chan Miss E Y-L
Chan Miss S Y Y
Chauhan Miss N
Cheetham M J
Choudhury Miss M M
Clark J S
Collyer Miss J
Cunnington P M D
Currie Miss A D M
Cutting C
Damoa-Siakwan Miss S A C
Dargan P I
Dasan S
Davies Miss T D
Downes T W
Easton P J
Edmonds S E F
Edmunds Miss L C +
Foley P
Ford Miss J A
Ford J C
Gall N P
Galletly N P * /
Gamage Miss A S
Gaon P D /=
Garstang J E $
Ghoorahoo H I $
Gil Rivas Miss S
Goodwin M W P
Groves Miss J C
Gupta R R
Gumpert Miss L C
Ha Miss Y W
Hall Miss L P
Hanrott Miss S F
Haq M I U
Haq S E A
Harden S P
Hardy R P
Hazel Miss S P C * +
Head Mrs F $
Henderson Miss E R
Holden Miss T R
Hulme Miss S-L
Isaac Miss J
Jacobs Miss C I /=
Jain S +
James Miss A M
Jelley A P
Jennings Miss S J
Jones Miss C E
Jordan Miss H A
Kabir J M M
Kanisius P H
Khan R J K
Khorsandi Miss S
Kidd R J G
Klein A A $
Knight J W
Knight R J
Kooiman G G
Lam D G K
Laurence A D J /
Lawman Miss S H A
Lees M
Leftwick P D J

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Maisey N R
Mannings Mrs N C
Marks Miss T =
Martin Miss H M
Martin Miss S L
Matthews J G
Maynard J R
Metha J R
Meurisse Miss F A
Miles Miss J C $
Miller M T V
Moodie S J
Moss C E
Moule S P
Nguyen H
Oakervee Miss H E
Parmar D N
Patel A M
Patel R
Patey R A
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Petre Miss H C G
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Sen D
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Sharma Miss K
Sharma R
Sharma Miss R
Sharples E J
Shaw A J
Siggers Miss G R
Simcock R A =
Skyrme A D
Smith Miss C L
Sodhi Miss R K
Speight J M $
Spurrell P A R $
Stanhope B G
Steer Miss S E
Stenhouse P D
Suddle A R
Taylor Miss A * +
Taylor A J
Taylor H J H
Taylor Miss R J
Thompson J B D
Tinkler Miss J
Townsend R M
Tsao Miss S S-L
Warren S J P
Watts Miss B L =
Watts D P / $
Wells Miss L C +
Wong G R
Worrell S J
Wu E B
Xavier Miss S M
Yeo Miss S I

The following students qualified MB BChir (Cantab) in June 1993:

Ahmad Miss N
Karim M Y * +

Lewis C J

Key:
* Distinguished in Pathology
\+ Distinguished in Medicine
/ Distinguished in Clinical Pharmacology and Therapeutics
$ Distinguished in Surgery
= Distinguished in Obstetrics and Gynaecology

Pathology distinctions

The following students obtained Distinctions at the final MB Part IV (Pathology) Examination in June 1993:

Barker Miss R M (Cantab)
Baxter R
Merry J
Taylor Miss J D
Thallon Mrs A

New Dentists

The following students qualified BDS University of London in July 1993:

Banerjee A
Butt T A
Dudhia M A
Dyke W J
Gledhill Miss H K
Heyes Miss C M
Lees Miss V C
Monteiro M J
Ngsiad Miss D M
Osborn Miss H J
Patel M
Popat S
Razaq Miss S T
Silva Miss R
Talati Miss X A
Vassallo P R

The following students qualified LDS in March 1993:

Banerjee A
Brown A D R
Czepiel Miss D
Dudhia M A
Ngsiad Miss D M
Osborn Miss H J
Patel M
Talati Miss X A

Deaths

COX, Alfred George Charlton, MD, FRCS, died on 11 June 1993. Husband of the late Betty and father of Christopher, Charles, Katherine, James, Margaret and Anne. Rest in peace.

SPENCER-PAYNE, Herbert Hartnell LDS RCS Eng 1941, died on 6 July 1993. Folkestone. So much loved husband of Marysia and father of Melegueta.

RHYS-JONES, William Gwyn (Bill) MA, LSA, BM, BCh, DHP, died on April 22 1993 at his home in Clive, Shropshire. Beloved husband of Cara and brother of Eira.

New appointment

Sir Terence English, a distinguished Guy's graduate who is a cardiac surgeon at Papworth Hospital and was until recently President of the Royal College of Surgeons of England, has been elected Master of St Catherine's College, Cambridge.

Birthday honours

Dr H M Tuddenham was appointed MBE in the Queen's Birthday Honours list, on 12 June 1993, for services to General Practice. Dr Tuddenham qualified from Guy's in 1957 and retired in 1991, after 30 years a s a GP. He is still Branch Medical Officer for the Hampshire British Red Cross.

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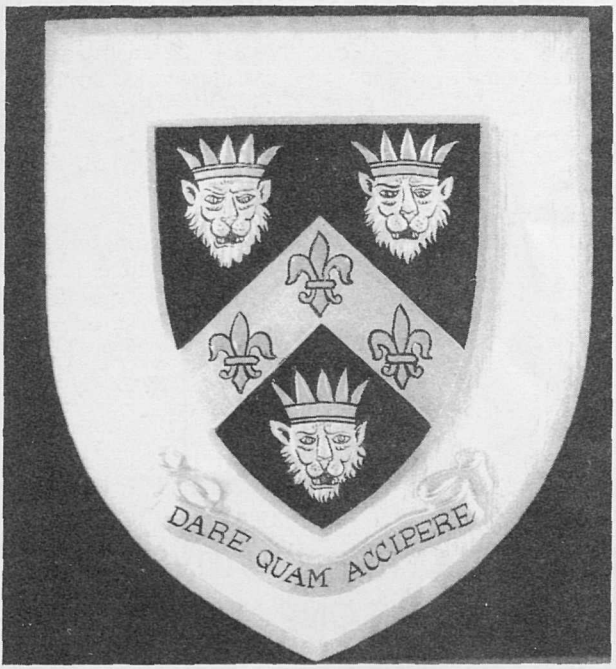

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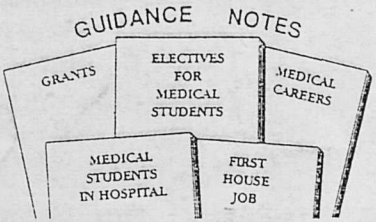

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- 150 Years—Guy's RFC
- Struck Off and Die—an interview

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CONTENTS

270 **Passim**

271 **Gazette Letters**—pushed to peripherals

274 **Gazette News**—NHS complaints

276 **Gazette Feature**—cycling in London

278 **Gazette Feature**—rugby football 1943

281 **Gazette Feature**—150 years of Guy's RFC

284 **Gazette Feature**—struck off and die—the interview

292 **Gazette Feature**—organ transplantation—the pioneers at Guy's

299 **Gazette Reviews**—pathology

300 **Gazette Obituaries**—Roger Arthur Abbey, Ronald Wilfred Willocks

302 **Nursing Notes**—our health

305 **Clubs Union**—rugby review

307 **Sport**—boat, rifle, hockey

312 **Classified and announcements**

UMDS Guy's
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Guy's Gazette

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The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

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Passim

October saw the arrival of the new Freshers, complete with welcoming booklets defining the objectives of each of the lectures that make up the new integrated part I course. This appears to be a definite improvement on the earlier, rather disjointed course where lectures jumped from subject to subject and system to system, making it difficult to grasp an overall picture.

Unfortunately, any change, even one in the right direction, often causes problems when it is integrated into a pre-existing scheme. The changes to the clinical curriculum for the new third years have had repercussions upon the organisation of the final year's final firms—see leading letter. One can but sympathize with the anxieties expressed at the use of peripheral attachments for their final block of ward teaching. Any break with tradition at such a stressful time is a source of anxiety in itself. Though peripheral hospitals do offer the benefits of many patients, the standard and amount of teaching is notoriously variable and the year is not sure exactly where they have been placed. If the use of peripheral attachments for final firms is to continue, we feel sure that the year below would appreciate knowing as early as possible, rather than three months prior to electives.

To continue with the subject of change, the Trust published a document outlining its assumptions regarding future income and productivity and describing the models of hospital organisation being tested in the option appraisal process. The Trust foresees, mainly as a result of changes in referral patterns, a drop in income of between £26–35 million /yr by 1998–99. This coupled with higher costs forecast, projects a financial deficit of £51–65 million (higher if one or other A&E department is closed). To remain financially viable the Trust foresees a reduction in expenditure of 25–33%, reducing manpower costs by 30% over five years.

The site options being considered consist of; 'no change'—an option the Trust considers not sustainable financially and one that would not allow achievement of full potential. It is being used as a baseline against which to test the other two options, namely; a single-site hospital, an option that reduces accessibility of care to local patients or a two-site hospital, an option that would depend on the Trust's ability to shed or find alternative use for the vacated parts of both sites.

Comments on the proposed strategy are asked to be received by 22 October and the Trust plans to submit its recommendations to the Secretary of State by the end of October. Though impossible to please everyone working within the Trust, it is to be hoped that the options chosen are those that offer the best to staff as well as patients.

Pushed to peripherals

Dear Sir,

We are writing on behalf of the final year medical students, regarding the proposed changes to our curriculum, on return from our elective in January 1994. We are opposed to the changes as we believe that they will have a detrimental effect on our preparation for finals.

The problem has arisen because of the introduction of a new clinical curriculum for the current 3rd year students. This has resulted in a ten week overlap period in the New Year when both 3rd and final year students require medicine/surgery teaching on campus.

This undeniable problem has, however been 'solved' in a way that we as final year students find unacceptable, as it is proposed that 3rd year students take preference for campus-based firms. The changes for the final year during this time are:

Group 1
6 weeks peripheral attachments
6 weeks on campus with larger firms

Group 2
4 weeks on campus with larger firms
4 weeks peripheral attachments
4 weeks on campus with normal -sized firms

These changes have not been properly discussed with us and were presented almost as a 'fait accompli'. However the year as a whole has the following anxieties which we would like to bring to your attention:

- Library facilities will not be available to us whilst we are away on peripheral attachments.
- The revision lecture course will be difficult to attend if we are away on peripheral attachments.

(The view of recent finalists is that revision course is invaluable in the preparation for finals.)

- Larger firms on campus will make ward teaching very difficult.
- The need for the completion of curriculum in sub-specialties has not been addressed.
- In some instance the time will not be equally divided between medicine and surgery.
- For students who are limited to public transport travelling to peripheral attachments will be costly and will make it virtually impossible for them to attend any teaching sessions taking place on campus.

Whilst peripheral hospitals do offer the benefits of many patients it is the consensus of the year that they are unable to match the excellent teaching offered by campus-based consultants.

From speaking to a number of consultants it is clear that they too are of the opinion structured teaching before finals improves the overall pass rate. We are speaking for all the final year students when we say that we are all frightened the massive numbers of failures which occurred two year ago at UMDS will be repeated in 1994. For these reasons we therefore respectfully submit that it would be more appropriated to give final year students a preference for campus-based firms. Most importantly an integrated and complete revision course must be preserved for all final year students.

Yours faithfully,

FINAL YEAR STUDENTS

A division of decision

Dear Sir,

Final year students have been understandably concerned at the way the medical school has handled the potential overlap with first year clinical students after the electives are over. Many students say that SMEC just doesn't carry enough weight to stand up to the 'powers-that-be'.

Some medical students from Hungary who recently visited Guy's explained that their university has a parliament in which students have a third of the votes. Does Britain, famous for its democratic system, have something to learn from Eastern Europe?

Yours faithfully,

FUAD HUSSAIN
Boland House
Guy's Hospital

UMDS reply to final year students

Dear Sir,

Thank you for giving us an opportunity to see the letter from final year students. We appreciate their concerns about the overlap period with the new curriculum. This does occur at a sensitive time for Finals. We have a practical problem with the teaching of four hundred students at this period. The alternative to the use of peripheral attachments would be to double the size of the campus-based firms, which we feel would lead to unacceptable numbers and to poor clinical experience. We decided that it would be best for the final year students to use the peripheral attachments because this would be of most benefit to them. All the campus-based firms will still be fifty per cent bigger during the overlap, and rather than spend all their time on these larger firms the senior students will be able to obtain access to more patients at peripheral attachments.

The proposed timings for Group 1 are a six-week peripheral attachment, then eight weeks back on campus with larger firms, and for Group 2 the first attachment would be six weeks with larger firms, followed by a peripheral attachment of four weeks and then back on campus with smaller firms.

With regard to the specific queries made in the letter from the final year students:

- There will be access to library facilities at all peripheral attachments.
- The revision course will not start before the return from peripheral attachments.
- The larger firms on campus will make ward teaching more difficult, but the problems will be eased by the peripheral attachments.
- A number of subspecialties, such as Rheumatology, Neurology and Dermatology, will not have an overlap period, and we should be able to fit in the teaching of these. It is a problem which will have to be addressed when we know who will be away for each specific period.
- Instead of seven weeks and seven weeks, the firms have been changed to six weeks and eight weeks. This decision was made following advice from the students that it would be better for all students to go out for some of the time, rather than some

students being away for the whole period.

- There will be a problem with travelling to peripheral attachments. We will try to give students some choice in the siting.
- We will give the consultants at peripheral attachments specific objectives, and the teaching will be structured for Finals. At each site, one tutor will take responsibility for the arrangements.

We do think that for the final year students, this arrangement will be more useful that spending the whole time on a campus- based firm which is fifty per cent larger than normal. We hope this answers some of the anxieties for the final year students. The overlap is inevitable, and will produce some problems, but we still feel it is the best solution for both third years and final year students.

Yours faithfully,

N T BATEMAN
MA,FRCP
Consultant Physican
Assistant Clinical Dean

P J REES
MD,FRCP
Consultant Physican

Guy's Hospital RFC
150th Season
Festival Day

Sunday 17th October

Honor Oak Park

Gates open 10am

Public School Wanderers v Medical Babarians

Kick-Off 3pm

SEGA--use in research

Scientists have found an alternative use for Sega amusement products; the company is otherwise best-known for their video and hand-held games. Scientists of the Medical Research Council (MRC) Human Movement and Balance Unit, at the National Hospital for Neurology and Neurosurgery, are adapting a SEGA R360, recently installed at the hospital, for use in studying problems of dizziness and balance loss.

Dr Michael Gresty of the MRC commented, 'The team at the National Hospital are clearly delighted with the potential applications of the SEGA R360 and the acquisition of the machine is the culmination of a five year search for a motion simulator with a high enough technical specification to meet the demands of scientific experiments and yet at a cost reasonable enough to satisfy the constraints of a research project.'

Tuberous Sclerosis Awareness--the right to know

The month of October has been designated as 'Tuberous Sclerosis Awareness Month' by the Tuberous Sclerosis Association. The association was established in 1977 and to date embraces 1200 families. It offers support to sufferers and their families and is also involved in research and education about the condition. It aims to increase awareness about this multi-system genetic disorder and the number of families it helps.

'Let lay investigators judge NHS complaints'

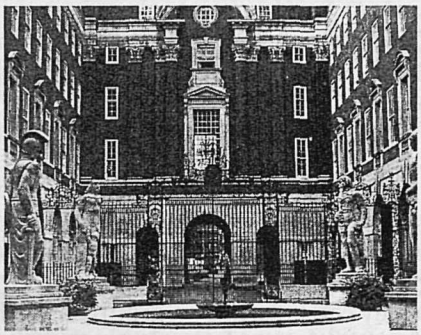
The NHS Support Federation, a national voluntary organisation with 10 000 supporters and 200 affiliated groups, is calling for independent lay people to play a leading role in NHS complaints.

In a submission to a Department of Health review, the Federation says that patient's confidence will be increased if they have the right to ask for an independent investigation of their complaint.

Independent investigators, from voluntary organisations or specially appointed panels, are already in use for dealing with social services complaints. The Federation emphasises that most complaints should be resolved at an early stage without recourse to independent investigations.

The Federation would like to see the current complaints systems replaced with a single system. It argues that a single system throughout the NHS will be easier to understand.

"If you need professional help"...



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Even medical students can receive help and professional advice from the BMA as well as the many other benefits carried with membership of the BMA Medical Students Group.

- Free copy of the Student BMJ (or usual BMJ in clinical years if preferred) and BMA News Review.
- Discounts on all insurance services (including very low electives insurance).
- Career information
- Personal advice from your local office
- Use of the BMA Library, the second largest medical library in the country.
- Discounts on consumer goods, including holidays, Next, Dixons, Currys and many more.
- Discounts on National Breakdown Cover, MOTs, tyres, exhausts, batteries and shock absorbers (all fitted free).

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Cycling in London

The perils and pitfalls

With tube fares increasing, walking an unheard of effort and parking at a premium, how do most UMDS students now choose to travel into college?

Well, as a recent survey carried out by a group of third year students as part of their community health course showed, over 60% of students cycle into Guy's and St Thomas's, daily taking their life (and lungs) in their hands on London's chaotic roads. Cycling may be good for the environment, but as many students reported, it can also be hazardous to your health--on average, those polled suffered one incident every five weeks. These 'incidents' ranged from falling off their bicycle whilst drunk (barflies note--being drunk in charge of a bicycle is an offence!), to more serious accidents involving cars and pedestrians.

PC Andy Jagger, the Community Involvement Officer for Southwark, says cyclists themselves are partly to blame for the rising number of cycling accidents (over 25,000 reported in 1991). 'Cyclists pick and choose which part of the road traffic law to obey. They say they get a raw deal from drivers, then they act like they're doing you a favour if they stop at red lights and pedestrian crossings.' This fact is borne out in the community health survey, with a large proportion of students having suffered their accidents while negotiating these self-same red lights and pedestrian crossings. However, student cyclists can take some comfort in thinking that, however lacking in road sense they may be, they can't even touch that specialised breed of cyclist, the cycle courier. Have you ever seen a cycle courier pull up at a pedestrian crossing, tip his hat at you and say, 'Have a nice day!' Forget it--he's far more likely to streak past in a dreadlocked blur, whipping off that toe you oh-so-tentatively put over the edge of the pavement in the process.

Cyclists, however, can hardly be blamed for every accident they are unfortunate enough to be involved in. In fact, rather a large proportion of accidents appear to owe their origin to the 'Man In A Van' syndrome. This combination of signs (small-brained man, large-sized van, big on bravado, low on road sense) forms a distinctive clinical picture indicative of a particular disorder which invariably results in a brush with death for the nearest unfortunate cyclist.

For example. One wet winter's evening last I was cycling across a zebra crossing. Along came a 'Man In A Van'. He saw me, had ample time to stop, but thought better of it--no, far more fun to scare the girly cyclist by waiting till the last minute and then screeching to a halt. Unfortunately, this particular 'Man In A Van' hadn't taken account of the rain. He slammed on his brakes, the van skidded and ended up in a tryst with my Raleigh Opal. My next all-too-brief encounter with a 'Man In A Van' was when one tried valiantly to overtake me on a narrow road. The next thing I knew, my handlebar had become locked into his wing mirror and I was sailing down Kennington Park Road at 40 mph, my legs going up and down faster than I thought was humanly possible.

Cycle accidents on London's streets account for over 17% of the national total. Add to this the fact that 79% of cyclists injured are male, and it seems that our male students are taking a definite risk every time they sit on the saddle. Over half the casualties suffered are head injuries, including skull fracture, concussion and abrasions. Good quality helmets can help to reduce the seriousness of head injuries, and prevent many minor injuries from occurring. Helmets are available to British Standard BS6863, and to other national standards.

Lack of conspicuity was assessed to be a contributory factor in 20% of cycle accidents where more than one vehicle is involved. Therefore, it makes sense to wear reflective clothing at night, or you only have yourself to blame if a driver suddenly flings his car door open into your path--a very common occurrence according to the community health survey. Miranda Champion, a fourth year student, suffered this accident herself, ending up with a sprained ankle and a broken front light. The story did not have an entirely unsatisfactory ending. The driver of the offending vehicle guiltily handed over £15 and Miranda spent an enjoyable night in the bar on the proceeds.

Miranda, however, is pretty small cheese in the lucrative world of cycle injury compensation. Another fourth year student, Mark Lewis, was recently awarded £650 after taking legal action against the driver who knocked him off his bicycle near his home in Deptford. Placing yourself and your bicycle into the path of a passing juggernaut, however, is not recommended as the solution to spiralling debts and shrinking student grants.

The conclusion is, therefore, if you don't want to end up in casualty on your way to the lecture theatre, do your part and cycle carefully--and don't forget to fasten your helmet.

Orna McGinn

Rugby football 1943

Guy's Ist XV v Rugby School Past and Present. The Close, Rugby school, 4 December 1943. Won 12-6.

The news that one of the celebrity events to mark the 150th anniversary of the foundation of the hospital's Rugby Football Club is to be a match on 28th November 1993 at Rugby School between Guy's Hospital and a Rugby School XV, prompts a recollection of the match described above. This was the first match that the Hospital had played on The Close at Rugby School and marked the 100th anniversary of the Rugby Football Club. Other commemorative events in 1943 included the centenary match v London Rugby Union, followed by a memorable supper for 80 people in the pavilion at Honor Oak Park (*Gazette* 1943. 57. 271-3) and a dinner-dance held at the Grosvenor House Hotel. In the club's centenary year W D Doherty was president, A B (Alan) Lee, now of Ripe near Lewis, was captain and I was secretary. A turnout of my rugby football archive also prompted this recollection.

Rugby School gave us a great welcome. The house-masters invited us to lunch. The sun shone. The band of The Royal Warwickshire Regiment played before the match and at half-time. The spectators numbered over 1,200. The *Rugby School Meteor* (14 February 1944) described them as, '..the largest crowd since 1923', when a match on The Close was played between England and Wales against Scotland and Ireland to mark the centenary of the game's birth on the ground. Due to the difficulties of war-time there were last minute telegrams before the match and the 3.15pm kick-off was postponed by ten minutes to allow the late stragglers time to arrive by taxi. D M Strathie and I, both of us Old Rugbeians (ORs), Oxford University players and Guy's men, were asked to play for the Rugby side. Other members of the Rugby side included M R Steele-Bodger who has since achieved international fame and distinction in the rugby football game.

In the first half of the match the Guy's pack tended to dominate the game. Tries for the hospital were scored by A C Macrae-Gibson and Graham. Early in the second half Gullick scored again for Guy's after a run by N K Macrae-Gibson. Then the game took fire and the Rugby forwards found new life. For the Rugbeians Strathie went over on his own for a brilliant try. This was soon followed by Walford scoring in the corner. In the final minutes of the game

Guy's 1st XV v Rugby School Past and Present--The teams

Willcock, the Guy's scrum-half, slipped over for a try from a scrum on the Rugby line to secure the game for Guy's. As the *Meteor* described it, '..with the score 12-6 to Guy's ended a game which, never tame, rose to a ferocious crescendo. A game of robust and clever football which delighted all who saw it.'

Among the spectators was a strong contingent of Guy's men. In addition to W D Doherty were J E Humphery, chairman of the Court of Governors at Guy's and two vice-presidents of the Rugby Football Club, Air-Commodore J J Conybeare (an OR) and J B Blaikley. Other Guy's men present included S H Wass, D M Carnegie (an OR as well), R E Williams, Dr Meacock, Flying Officer Gilbert and R E Smith. R E Smith, a former Guy's medical registrar and the Rugby School doctor in 1943, did a great deal to organise the successful arrangements for the Guy's XV's visit. He no doubt engineered the venue for the dinner given by Rugby School's headmaster, P H B Lyon, to the two teams and others. This was held in the then school sanatorium. The menu for the dinner comprised clear soup, roast lamb, baked potatoes and brussel sprouts followed by mincemeat tart with cream and toffee. It was an excellent wartime dinner. Those members of the competing sides who so wished were invited to spend the night in the sanatorium where they were brought break-

fast in bed the next morning. As the contemporary account in the *Gazette* (1943. 57. 285) concluded, 'It was a great weekend.'

T L T (Tom) Lewis published one of his histories of the Hospital Rugby Football Club to mark its 125th Anniversary (*Gazette* 1968. 82. 582-615). In this he quoted that, 'It is the pride and joy of all members, past and present, of the Guy's RFC that theirs is the oldest in the game's history.' As such it is appropriate that the club should be able to play, through the kindness of Rugby School, on the ground where the game was born, to mark the club's 100th and 150th anniversaries.

The writer feels sure that he speaks for all the surviving Guy's men who played at Rugby School in 1943--sadly at least four of them are known to have since died--in wishing the Guy's side a successful match and an enjoyable day when it visits Rugby School on 28th November 1993 to mark the Guy's RFC's Sesquicentenary.

Anthony Batty Shaw

Guy's Hospital RFC
150th Season

Guy's Hospital v Old Rugbeians

Sunday 28th November 1993

'The Close'

Rugby School

Guy's Hospital RFC

Sesquicentenary of the world's oldest rugby club

The men and women of Guy's have created an illustrious name for their hospital in the field of medicine, but it is little known that Guy's men have been leaders in the creation of our national sporting heritage. Guy's Hospital Rugby Football Club, founded 1843, is, would you believe it (and the Guinness Book of Records and the Rugby Football Union most certainly do) the 'World's Oldest Rugby Club'.

The evidence for the Club's foundation is circumstantial but never-the-less strong. No challenge to our claim has withstood the test of time or the scrutiny of the historians. J B G Thomas, in 'Great Rugger Clubs' (Stanley Paul, 1962--now sadly out of print) summed up our feelings about the matter sufficiently, 'It is the pride and joy of all members, past and present, of Guy's RFC that theirs is the oldest in the game's history. Of this there is no doubt, despite the claims of other distinguished bodies to the worthy 140 title.'

The 150th Anniversary Season

Medics rarely need an excuse to organise a party, particularly when the occasion is actually worth marking. Thus it was that Dr Terry Gibson assembled, as far back as 1990, a committee, under the Chairmanship of Mr T L T Lewis CBE, FRC, FRCOG. In the early years we debated subjects, ranging from the likelihood of the Barbarians playing at Honor Oak Park to the number of sides put out every Saturday by Stellenbosch University--is it 76 or 96?

After much deliberation we have settled on the following programme of events, which I shall set out in full for the benefit of your diaries:

Sunday October 17th 1993--Festival Day for Rugby at Honor Oak Park

11.00am Band of the Kent Police
11.30am Guy's Veterans v Blackheath Banshees
12.45pm Guy's Ladies XV v University of London Ladies
1.45pm Guy's Ist XV v United Hospitals
3.30pm Public School Wanderers v Medical Barbarians (Aesculpians)

The Medical Barbarians side will include Mr Jonathan Webb of Bath and England plus other internationals past and present. Seats will be available in both the permanent HOP stand and a temporary stand and a full range of refreshments provided.

The proceeds of all these events will go to the Rugby Football Union Charitable Trust and our own James Hawker and Alex Boulger Memorial Funds.

Guy's Hospital Ist XV v Old Rugbeians. Sunday 28th November

This match will play at 'The Close' at Rugby School, the site of Webb Ellis's indiscretion, and will kick off at 2.30 pm.

Friday April 29th 1994

150th Anniversary Dinner at the Waldorf Hotel, Aldwych, London. Past members of the Club wishing to attend with their teams should contact Professor Challacombe, Department of Oral Medicine, Guy's Hospital.

July 1994--Tour of South Africa

There are plans afoot to tour South Africa, a rugby playing nation with which Guy's has close links. The tour will visit Cape, Durban and Johannesburg.

The Guy's Tradition

Our claim to being the World's Oldest Club rests on the testimony of Sir Frederick Taylor and Mr J N C Dawes-Colley (who entered Guy's in 1863 and 1865) to Dr Alford Allport. In Dr Allport's own words, 'This may be taken as substantial confirmation amounting to certainty, for men's memories carry back thirty years with accuracy and if the 1843 date was admitted in 1874 by other hospitals (Mr E B Turner of St George's), it may be accepted as the correct one.' A future card for the year 1883-4 attests to the club's football season. 'Indisputable proof' of our 1843 foundation according to an article in the *Referee*, October *1921*.

The United Hospital's Cup was inaugurated in 1875 with a win for Guy's, beating St George's in the final by one goal and one touchdown to two touchdowns. The *Gazette* reported, 'The fierce struggle, the running, the kicking, the intense excitement and cheering of the spectators form a picture that we shall recall when we are old--old in years, but which will make our pulse beat again with the features of youth. The players in the Guy's team, like the old victors at Agincourt, will raise their heads with pride at every anniversary of March 3rd, 1875.'

From the turn of the century, Guy's took a definite place amongst London's, first-class clubs. The standard of the players was very high and a substantial proportion played in representative matches. Guy's supplied a regular stream of international players and a substantial part of the representative teams touring the Antipodes. In the 1906-7 season, Guy's copied the New Zealand policy of allotting fixed places in the scrum for the forwards. This was, as a tactic, likely to cause delay but was soon adopted by Wales and then univer-

sally. Once again, Guy's were the pioneers of a development in rugby football that was to become accepted practice.

On Thursday March 12th 1908, an event of great historical importance to Guy's took place. As the train to Richmond, crammed full with Guy's supporters on their way to the Cup match with the London, halted for a while at Vauxhall Station, a milk churn was somehow 'acquired'. This has been the 'supporters' mascot' from that day to this and is paraded at every Cup final in which Guy's plays. The churn is currently under the custodianship of the Medical School Office.

The four years after the war 1919-23 were undoubtedly the brightest in the whole history of Guy's rugby. The Hospitals' Cup was won in each of these years. Guy's successes drew great crowds to Honor Oak Park and spectators were often turned away. To make sure of a seat in the stand, one had to be there three-quarters of an hour before the kick-off.

The break-up of the great team of the early twenties marked the end of Guy's ascendancy in English rugby. It is interesting to note that in 1925-6, when Guy's lost the Cup 5-0 to St Thomas's a storm of protest followed the usual Cup Final rag (details not supplied) and there was a strong attempt to dispense with it altogether because of damage to property and annoyance to the public. Guy's remained a first-class club until well after the Second World War, and retained first-class fixtures until the early eighties. The wartime centenary celebration included a match against Rugby School Past and Present played on the historic Close at Rugby School (see preceding feature). A match against United Hospitals was lost by 13 points to 6. Guy's have an opportunity in the forthcoming season to avenge this defeat.

While Guy's is no longer a leading light in English Rugby, it remains synomynous with the concept of an innovative and proud sporting tradition. The players of Guy's Hospital RFC remain fiercely and justly proud of their rugby heritage. The spur to press ahead and win the Hospitals' Cup in this, our 150th Anniversary Season will be a sharp one.

James Thallon

Abridged,in parts, from Mr T L T Lewis 'A Short History of Guy's Hospital RFC'

Struck Off and Die--the interview

Guy's bar, Friday 23 July 1993--the place

Following a number of successful shows throughout the country and at the Edinburgh Fringe, comedy duo, 'Struck off and Die' (Dr Tony Gardner and Dr Phil Hammond) have recorded a series of shows for Radio 4, broadcast over August. Robert Self (*Guy's Gazette*) and Damian Gamble (*SE1*) met Tony Gardner in Guy's Bar to discuss comedy, careers and, some would say, a fairly unorthodox view of Medicine.

Robert Self: We wanted to ask you a bit about the history of Struck Off and Die; how you met and that sort of thing.

Tony Gardner: I qualified from Guy's in '87 and Phil went to Cambridge and St Thomas's, again he qualified in '87, and we met up when we did our house jobs in Bristol. Phil did quite a lot of shows at Thomas's--Christmas Shows, he was involved in all that scam--'Beverly Hills Plop' and that sort of thing. We didn't have that much here [Guy's]. I did one thing here, 'Jack the Ripper' I remember, and 'Oh, What a Lovely War' I did as well. I went up with the London to Edinburgh in '85 and I also did the Inter-Hospital Review--I don't know if that's still going is it? It had the best bits from all the reviews from all the medical schools, it was always really good. Then we did a Christmas Show at the hospital in Bristol which Phil directed and we both wrote and performed in, called 'The Wibbly Wobbly Spanky Botty Show'. Then we thought about a year later that we could probably end up producing Christmas Shows, Phil had done one in Bath and one in Jersey, and I'd done one in Taunton. We were just ending up doing all that, and we decided we wanted to get together and take a show to Edinburgh. We went to Edinburgh in 1990 for the first time and performed Struck Off and Die in March that year. It went very well that year at Edinburgh and we got a lot of national press because of what we are doing--we set it up that we were going to be struck off by the General Medical Council and we had a pretty slick show there--a lot of press coverage, a lot of radio coverage, and we're been up there every year since, working fairly non-stop since then, with various projects. In 1991 we got the Perrier 'Pick of

the Fringe' award, so we got a run down in London as well, in the Festival Hall.

RS: You did some TV around then as well...

TG: We've done a bit of TV. We've done some documentaries for BBC2 and various things--we're always asked to do these sorts of things. Phil's the Agony Doctor for 'Five' on Radio 5, I write for *Hospital Doctor* every fortnight, Phil writes for *Nursing Times, GP* and another magazine, though you'd probably better not mention which. I believe you start off writing from personal experience. That's the whole thing about 'Struck Off and Die' and that's why we're doing quite well. Having said that, we're now branching out into non-medical stuff, and we took a non-medical show up to Edinburgh this year called 'The Porky Palmer Show'.

RS: Are there any Medical School stories you want to tell quickly; any anecdotes or amusing things...

TG: (Laughs) Yes, lots... I don't know if there's any I want to tell!

RS: What's your favourite amusing anecdote about Medical School, or one of your favourites...

TG: I don't know really... Spiros--I still go on Spiros every year, that's good. No, none that spring to mind. Lots of disgraceful horrible stories, like when we used to come down here and have a blender night... This bar was a lot smaller when we came.

RS: What do your think of the new bar?

TG: It's like a cross-channel ferry. It's still horrible and sticky when you walk across the floor, and the effect is the same as a cross-channel ferry. You come down here and feel incredibly sick, the room starts spinning--it all fits--it's a dreadful place. The students used to run their own bar here--we didn't have a barman, until they started losing about a thousand pounds a week. It was just horrendous when I was down here. It was pretty rough, but we had a good time. No, I don't like the bar as much now. I very much resent the fact that you have to pay to get down here on a Friday night, I think that's disgraceful, I really think that's appalling--the hops used to be upstairs. And it was forty-two pence a pint when I came here!

RS: What do you think of the merger with Tommies?

TG: We'd seen it coming even when I was here, we realised that things were going to happen. I took it for granted really, I never really got involved. I used to feel quite a lot of anger towards it initially. I haven't got any strong feelings on it, I think it's inevitable that one is going to close. When we were here, they were building all these 200 seat lecture theatres and you used to wonder why. I'm a bit out of touch with it all. I'm in touch with the fact that there's a

McDonald's in what used to be the Upper Spit, which I think is just a travesty, it's a disgrace, but there you go...

DG: Obviously a lot of your humour is based around Medicine. Do you think most of your audience are in the profession or does it appeal to a more general audience?

TG: It depends what we do. I think because of what we do, we always get a high percentage of doctors, nurses, medical students. I think we're more well-known in the medical profession than in the general public. But with the NHS being the largest employer in Europe, you're going to get a lot of people just coming along! We do lambast the profession--they do enjoy it-- but it's often more rewarding when it's a non-medical audience, and that happens at Edinburgh, we get lots of people just coming in off the street. The public are very interested, everyone's got their own experience of doctors and they like to hear us taking the mickey out of each other. We're always selling out and doing very well, but I suppose it's a false economy in a way, and that's why a lot of the other comedians on the circuit would say that we're a 'speciality' act. I don't know, maybe we are.

DG: Do you ever offend people in the profession?

TG: Yes, less so than we used to, but we're coming back this year with a 'Best Of'. We've done three different shows in the last three years at Edinburgh, this year we're doing the 'Best Of', and we're coming back with all the sketches we got put down for, including one that had the record number of complaints for a Radio 4 programme, and it was upheld by the Broadcasting Standards Council. I remember that one! I don't think we're going to do that particular sketch. But yes, we have offended quite a few doctors, but the majority--no, but I suppose the majority who are offended wouldn't actually say anything. But those that have found initially that it was wrong to undermine the 'professionality' of our profession, to go up there and say that we laugh, when patients die, and we try to get 'ash cash' off people. They thought that it was just undermining things but, in general, people are very interested, and very encouraging. I don't think that if we had stayed in hospital medicine we'd be doing ourselves any favours. You know we're both GPs.

DG: Would you regard anything as being beyond the pale now? Is there anything that you'd just completely steer clear of making jokes about?

TG: That's the sort of thing that you'd ask any comedians, and they always say 'child abuse'. We've taken things probably slightly too far on occasions, certainly in our first year at Edinburgh, talking about death and dying, and that the way you cope with it is to laugh at it... the black humour of doctors and nurses. We'd certainly steer clear of overt racism and anti-semitism and things like that.

RS: You're both GPs now. Would you do such dangerous stuff if you were in hospital medicine, if you were SHOs, or if you were Registrars now...

TG: I think we probably wouldn't, no. As I said earlier, I really don't think you could.

RS: Because...

TG: Because, you know what the situation is where you've got a closed reference system, and your job depends on what your last reference was like. You don't want to start rocking the boat. It's such a difficult profession, anyway, to get to the top in. You've got to keep quiet, and tug your forelock and say 'I don't want to make too much of a fuss'. Phil's working as a lecturer in General Practice, he teaches Medical Students how to communicate, and I'm a trainee so I haven't finished yet. I shall be taking another year out to try to make a go of acting for a year, just to see what happens. I've got a lot of work on, what with the radio series and everything, so...

DG: Do doctors get a bad deal? You mentioned before about the reference system. The way I see it is that doctors get treated fairly roughly for their

trainee years and they can't complain about it. Then when they become consultants they basically do exactly the same to people under them.

TG: That is what I suspect happens. It's terrible, it's really bad, and you often find that it's the younger consultants who've just got there that are the nastiest, the overall feeling being, 'Well I had to do it and so should they'. It's actually been likened to forms of child abuse, where you're beaten up as a child, then you grow up and you beat up your own children...

DG: You have to be careful about making jokes about child abuse...

TG: I know, but it's not a joke, it's true! It is a bad thing, and I realised very early on in my house jobs that I didn't want to be in hospital medicine, for that reason. I just couldn't bear trying to be nice to people all the time when you actually hate them.

RS: Even if you weren't doing the comedy, would you still be in hospital medicine?

TG: No, I decided to go into the General Practice early on. So I had a life outside Medicine, I suppose.

DG: Is Struck Off and Die a political show? Are you trying to change things?

TG: We initially started off with quite a naive view that maybe we were going to change things, and we did dabble in Medical Politics. Phil certainly did a little bit, and we kept being asked to be on these committees for various hospital doctors' associations. Eventually we came to the conclusion, that doctors are intelligent people and if they can't sort out their hours and their working conditions, then quite frankly they deserve the mess that they get themselves into. It is an awful thing to say but I really do believe that now. The things that people do put up with in hospital medicine--it's quite shocking and I've just given up on the political front. We still mention it now and again but I don't think anything seriously is going to change.

DG: Is it because junior doctors don't really have a group to represent them?

TG: It's because we haven't got a union. People say that the BMA is union, but I can't see how it's a union, being run by consultants and GPs. There should be something run by junior doctors. They tried to form it with the Hospital Doctors Association, but hardly anyone joined--it has about 3000 members. But as long as medicine is considered to be a vocation--it's an honour to be a doctor, not a job--then that's as long as the view that we shouldn't have worker's rights will be maintained. We're not workers as far as everyone else is concerned. Things are improving, but I've yet to see any major improvement. We still maintain high rates of suicide, alcoholism and drug addiction.

RS: Which comedians have inspired you? Which doctors?

TG: Phil Hammond!

RS: As a comedian or as a doctor, or both?

TG: No, Doctors who've inspired me? My own GP at home, I suppose, because that's when I first decided I wanted to be a doctor. I met quite a few nice consultants when I was working here at Guy's. I can't remember any names off-hand. And the comedians... they're probably the same people as the doctors. Well actually no. Stan Laurel, that'll do. He's about the only one I can think of.

RS: If you had to choose either comedy or medicine...

TG: We're never going to be working at the Comedy Store, because we're not stand-up comedians... but I really don't know. I think I actually thrive on the fact that I don't know what I'm going to be doing in a year's time. It's a difficult question. I'd very much like to do both, and I think I will do both, but you're thinking of leaving a profession which has 100% employment, I could be a GP and earn fifty grand a year, dropping all that and working for nothing in the acting profession which has 80-90% unemployment... I don't know, they've both got their attractions. I can't answer that question. It's one that everyone always asks us.

RS: Which has been your 'nightmare' show?

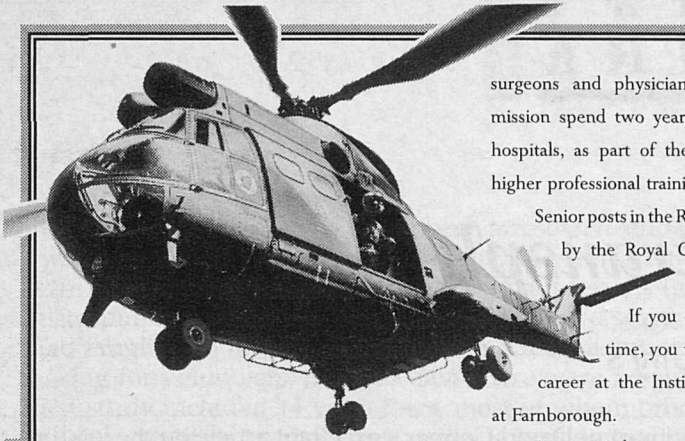
TG: We did a show for the Motor Neurone Diseases Associations once, and we did a cabaret after dinner. And after dinner they had a lecture by someone, a famous chap from the other side of the world, a long lecture, with slides, all about Motor Neurone Disease! We were watching this and thinking, 'How do we follow this?' And at the end someone stood up and said, 'Well, thank you Professor Johnson for telling us about Motor Neurone Disease and hopefully over the next couple of days at this conference we'll be able to help these poor unfortunate people with such an incurable disease that cripples and maims. Anyway, here's 'Struck Off and Die'.' It was awful. We died a death. But we've always been very lucky in having quite good audiences. You die sometimes. They say that you have to die at least a hundred times before you learn your craft in comedy, and I think it's probably true. We've learned more from the ones that have gone badly wrong than the ones that have gone well.

RS: When do you think medical students grow up, if ever? Is it the first day you're a doctor?

TG: Some people grow up the first day they're a medical student. I think it's just the same as anything else, you find a lot of your friends doing other jobs, and some mature faster than others. It's an interesting question. A lot of people grow when they become partners. I'm quite fearful of the fact that if I became a GP partner, I'd have to grow up quite quickly and be an established member of the community. I couldn't bear that. I'm quite happy going out and standing on stage. Medical students may well never grow up. I suppose, it depends... there are different types of medical students, basically two. Those that come down here [the bar] and those that don't and stay in the library. The ones that come down here probably don't grow up...

The interviewers wish to thank Dr Tony Gardner and Dr Phil Hammond for their co-operation.

Robert Self and Damian Gamble



surgeons and physicians on a permanent commission spend two years' further training in NHS hospitals, as part of the four-year programme of higher professional training.

Senior posts in the RAF hospitals are recognised by the Royal Colleges, and accreditation is identical to the NHS.

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You won't have to compete for a new job at each career level – unlike the NHS. But you will probably have the chance to work in the RAF hospitals in Germany and Cyprus.

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Organ transplantation

The pioneers at Guy's

This is the second part of David Cooper's excellent article on the leading role that 'Guy's Men' have played in the field of organ transplantation. The first part of the article featured summaries of the reminiscences of Bernard Amos and Sir Roy Calne and an outline of the contributions made by Peter Gorer. It appeared in the July-August edition of the *Gazette*.

Richard Batchelor

Richard Batchelor, like Bernard Amos, has been one of the leading tissue immunologists for the past 30 years. Although born in Woking in 1931, he spent part of his childhood with his parents in India, before returning to school at Marlborough. He read the Natural Sciences for Medicine Tripos at Cambridge University, and completed his clinical medical studies at Guy's between 1952-5, where his interest in pathology was stimulated by Professor George Payling-Wright. He then spent one year at Pembury Hospital in Kent before being called up into the Royal Army Medical Corps. In 1959 he joined Peter Gorer's laboratory in the Department of Pathology at Guy's where he presented his MD thesis in 1965.

In 1967 he was invited to become the Director of the McIndoe Memorial Research Unit at Queen Victoria Hospital in East Grinsted, where he was able to develop further his interest in transplantation immunity, which included HLA matching for renal, skin and corneal allografts and immunological enhancement of rat kidney grafts. He combined this appointment with continuing to run the Guy's HLA tissue typing laboratory until 1979. In that year he moved to a personal chair in the Department of Immunology at that centre in 1982.

When he began his work at Guy's in 1958, transplantation immunology was not on any syllabus, there was almost no clinical transplantation, and there were very few laboratories in the field. Batchelor admits that it took him almost a full year to begin to understand the full scope of Peter Gorer's perception that the mouse major histocompatibility complex was potentially an important model for man. When Gorer died unexpectedly in 1961, Richard

Batchelor, although he had only been a research student for little more than two years, found himself to be the senior person left in the department.

In early 1964, Batchelor decided to join a serious investigation of human histocompatibility antigens. After Frank Ellis, a surgical colleague at Guy's, had taught him how to skin graft, he put up a notice in the medical school asking for volunteers; in those days there were no ethical committees! The first study included 14 volunteers, most of whom produced useful lymphocytotoxic antibodies after three consecutive skin grafts. Surprisingly, none of them developed any haemagglutinins. This made it clear that the human homologue of the mouse H2 system was not one of the previously identified human red cell antigen systems.

In the development of tissue immunology, Batchelor gives much credit to the histocompatibility workshops that were arranged at frequent intervals in those days, and believes they had a revolutionary impact on the development of this field. He credits the first workshop, in 1964, to the initiative of Bernard Amos and Paul Russell (a surgeon-immunologist in the USA). There was no consensus of opinion as to the best technique of identifying leucocyte alloantibodies. At the second workshop in 1965, it was shown that different laboratories were able to identify the same antigens in many instances, that the extent of the polymorphism was large, and that it was imperative to agree upon a standard terminology flexible enough to allow for new findings. It was also evident that the distribution of some antigens in the panel of volunteers was not random, confirming many earlier studies at individual laboratories.

Largely on the basis of significant positive and negative associations of leucocyte antigens in panels of unrelated subjects, Jean Dausset proposed the existence of a single system, which he named the Hu-1. Batchelor was unimpressed by this because he felt that Peter Gorer and his students had already demonstrated the likely pattern by their analysis of the mouse H2 system. It seemed most improbable that man was going to differ fundamentally from the mouse. What was needed, in Batchelor's view, was evidence demonstrating associated inheritance from parent to offspring of all the newly defined polymorphisms. The next task, recruiting and bleeding families, proved highly educational for him.

As a medical student learning midwifery, Batchelor had delivered infants at homes in Bermondsey and Southwark, but he admits he was unprepared for the difficulty of this phase of his research, which consisted of drawing blood from all the members of a family who generously agreed to volunteer as white cell donors. One family, with 13 children, lived in three small rooms and had a large fierce Alsation dog. Batchelor had to draw blood while kneeling on the floor with the dog growling in his ear!

From this work Batchelor was able to report the inheritance of the leucocyte antigens he had detected in the parents and offspring of 17 families. At the third histocompatibility workshop, 11 families were tested by the 16 medical teams present, and the data confirmed that most of the leucocyte antigens detected were determined by a single genetic system. At the next workshop it was agreed to name these two allelic series polymorphisms HLA-A and HLA-B. When it was decided that for the fifth workshop the medical teams should study populations other than easily accessible Caucasoids, Batchelor was invited by Peter Morris, now Professor of Surgery at Oxford but then based in Melbourne, Australia, to join him in the New Guinea highlands to collect the necessary material. He was also involved in the collection of specimens in Fiji. (Batchelor reports that, in New Guinea, it was an occasional habit that the older women would welcome a male stranger by sliding a hand of greeting up the shorts and gripping the stranger by his manhood! Batchelor had been warned about this tradition and managed to escape this attention. However, he took considerable pleasure in observing Peter Morris's expression when he, ignorant of the custom, received this unusual welcome!)

In his reminiscences (1), Batchelor characteristically rather downplays his own pioneering efforts. For example, he does not mention his experimental experience in controlling rejection by immunological enhancement with antibody. In this work he was clearly one of the pioneers in exploring the interface between humoral and cellular responses. Nor does he include reference to his seminal studies on the relevance of HLA for corneal transplantation.

Richard Batchelor has played a significant role in the development of tissue immunology in re-

Richard Batchelor

lation to organ transplantation. This role was recognised by the members of the Transplantation Society who elected him their President in 1990.

Folkert Belzer

Of Dutch parentage, Folkert (Fred) Belzer was born in 1930 in Indonesia and studied medicine at Boston University in the USA. Between 1964-5 he held the appointment of senior lecturer in surgery at Guy's, where he worked under Professor Sir Hedley Atkins. Since 1974 he has been Head of the Section of Transplantation and Chairman of the Department of Surgery at the University of Wisconsin. Although he is included in this review of 'Guy's Men' who have been pioneers in organ transplantation, it was not until he returned to the USA from England in 1965 that Belzer became involved in the field of transplantation surgery. Over the past 25 years, Belzer has arguably contributed more in the field of organ preservation than any other individual.

At the University of California in San Francisco he was set the task to develop a cadaver kidney transplant programme. At that time brain death had not been clinically accepted by either the medical profession or the public. Therefore, in the first few transplants performed at that centre, the donor operation was not begun until cardiac arrest had occurred. When one of the kidneys had been removed and looked suitable for transplantation, the recipient operation would commence. The kidney was rushed from the donor centre to the recipient centre where it was transplanted immediately, every effort being made to limit the ischemic time to a minimum.

It soon became obvious that a better method of kidney transplantation was necessary. Specifically, there was a need for an improved method of preserving the kidneys so that, firstly, higher quality kidneys could be obtained and, secondly, there would not be such an emergency created by the procedure. Belzer therefore turned his attention to the laboratory to work on this problem.

Hypothermic perfusion of the kidney seemed to be the method of choice. Continuous perfusion of an organ with whole blood resulted in an increased perfusion pressure within 30 minutes, indicating deterioration of the organ. Belzer therefore switched his attention to the use of plasma as a perfusate, with more successful results, although consistent viability could not be obtained. Belzer points out that, although the success generated in any laboratory depends on, '..inspiration and perspiration', it also helps to have some luck, and this he had during the course of these studies.

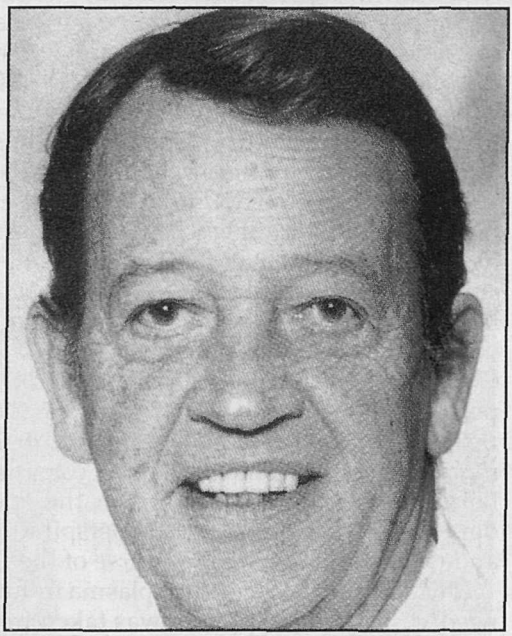
It was his routine to collect plasma from donor dogs, and store it frozen until needed. The frozen plasma was taken from the freezer and allowed to thaw overnight prior to the experiment. One morning when he arrived at the laboratory, he found that the plasma had not been removed from the freezer

the night before. Rather than postpone the experiment, he thawed the plasma rapidly by running it under hot water. To his surprise, the plasma was very turbid, quite unlike that which had been thawed slowly. To obtain a clear solution, he filtered the plasma. The dog perfused with this filtered plasma did not show a rise in perfusion pressure, and the kidneys functioned well after 24 hours preservation and autotranplantation.

Subsequent studies demonstrated that freezing and rapid thawing produced coalescence of unstable lipoproteins in the plasma, which were then removed by filteration. Belzer named the new solution 'cryoprecipitated plasma', and used it to preserve dog kidneys for up to 72 hours with 100% survival after autotransplantation. This method was then tested clinically. In the first patient, the transplant was performed after a total kidney preservation time of 17 hours. The kidney functioned immediately, although not perfectly, and hypothermic perfusion preservation of a human kidney had become a reality. This preservation system allowed cadaveric kidney transplantation to cease being an emergency procedure at Belzer's hospital, all kidney transplants being performed electively during daytime hours.

The San Francisco group did not have a perfusion machine that was sufficiently portable to carry to the donor hospital, and so an unattended hospital laundry cart was 'requisitioned'. The early perfusion machines were cumbersome, and it took two or three people to move the machine on the laundry cart. However, with the help of a rented Avis truck and a forklift, the group was soon able to take its machine to any hospital in the vicinity. The system was subsequently made available commercially by American Hospital Supply.

Steps were taken to minaturize the preservation machine, and a truly portable unit was devel-



Folkert Belzer

oped. Its first clinical use arose over Christmas 1971. Belzer had harvested two blood group A kidneys, but there was only one suitable local recipient at that time. He telegraphed a colleague in the Netherlands and found that he had a potential recipient for the remaining kidney. Belzer took the next plane from San Francisco to New York and transferred to the overnight flight to Amsterdam. It was Christmas Eve and the first-class compartment in the 747 jet was empty except for one other passenger. Thus, Belzer had the undivided attention of five stewardesses, who maintained a constant supply of ice to keep the kidney cold. After 37 hours of preservation, the kidney was successfully transplanted. The recipient returned to a normal life-style, with excellent kidney function, until he died 17 years later from a ruptured berry aneurysm. This portable machine was subsequently manufactured commercially by Edward Laboratories and, with some simplification, it is still used today.

In 1974, Belzer moved to Wisconsin, where he has developed one of the most active multi-organ transplant centres in the USA. When he took up the post, he found a small and poorly designed departmental research laboratory. He soon demonstrated, however, that a group's productivity is not necessarily related to the extent of laboratory space.

He and his group turned their research attention to understanding the basic problems of organ preservation, specifically those relating to mechanisms of ischemic cellular injury and methods to improve organ preservation with the aim of obtaining truly long-term kidney preservation--weeks to months rather than hours or days.

This research endeavor led to the introduction in 1987 of a purely synthetic solution--the University of Wisconsin (UW) solution--now widely used for organ preservation, particularly for the liver, where it has extended successful preservation from less than 4 hours to 12-24 hours. A modified version has provided safe 3-day preservation of the kidney and has replaced cryoprecipitated plasma as the solution of choice. UW solution has also been shown to be effective for the pancreas; in the clinical field, pancreas transplantation has been performed successfully after periods of up to 30 hours, with excellent results.

UW solution has therefore allowed elective and scheduled liver and pancreas transplantation to become a reality. Although organ retrieval is carried out whenever the donor becomes available, the recipient procedure can be scheduled for the following morning.

Belzer concludes that he has derived much satisfaction from teaching students, especially surgical residents and transplant fellows. 'The Laboratory, however, has been the most stimulating to my intellect, both when things went well and when there was little progress. The experimental laboratory

provides an opportunity to be creative and to make discoveries that can improve the quality of life for our patients.'(2).

Jan Klein, at the beginning of a review of Peter Gorer's work quotes a phrase from Shakespeare's 'Macbeth' that might apply equally to the initial idea of a researcher and to the young research worker himself,

'If you can look into the seeds of time,
And say which grain will grow and which will not,
Then speak to me.'

The scientific seeds planted by the five immunologists and surgeons highlighted in this article have provided us with grain in abundance.

David Cooper

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Pathology

General and Systemic Pathology. J C Underwood. Published by Churchill Livingstone. Price £19.95.

This is a new textbook of pathology aimed specifically for medical students sitting the pathology finals. It covers the major topics in both general and systemic pathology as well as some of the smaller print. It does not however attempt to be a reference volume of pathology in the same way that for example Muir's does. There is also a section on immunology that offers an extremely good basic overview of the subject; something that is all too often lacking in dedicated immunology textbooks. At the start of each section in systemic pathology there is also a useful overview of normal structure and function.

When I first saw this book I was very impressed with its format and layout. The text is presented clearly, subdivided into easily digestible sections with extensive use of summary boxes and tables. Each chapter ends with suggestions for further reading, and there is a more useful (for medical students anyway) glossary at the end of the book. This book is excellently illustrated with 400 full colour photographs of both gross specimens and histology. It is well worth going through these photographs just prior to the practical exam to refresh one's memory. Diagrams are also widely used to complement the text.

My criticisms of this book are few and far between. There are some subjects which are important topics in our course (and in examiner's minds) that are not dealt with in enough detail, such as rheumatic fever. In other topics lectures and the revisions books in the Gordon Museum are more comprehensive and perhaps nearer the standard of knowledge we should be aiming at. There has also been a failure of proofing in this first edition, leaving numerous references within the text to a mysterious p.000.

I would unreservedly recommend this book as the basis from which to revise for the pathology exams to the vast majority of students. Honours candidates should look elsewhere, or at least supplement Underwood with other sources.

Fuad F Hussain
Final Year Medical Student

Roger Arthur Abbey

Roger Abbey died peacefully in All Saints Hospital, Eastbourne on 7 July 1993, three days before he and Phyl would have celebrated their Golden Wedding Anniversary.

Born in Woolwich in 1914, he and Phyl were married during the war while he was serving as a dental officer in the RAF and Phyl was in the WRENS. Qualifying at Guy's in 1938 he was appointed house surgeon in the Children's Department before joining the RAF in 1939. As Senior Dental Officer, Suez Canal Zone, he was in charge of some thirty Dental Officers and the supporting laboratories, and later as an SDO (Air Ministry), jointly responsible for the clinical training of Dental Hygienists.

On demobilisation in 1945, he set up private practice in Eastbourne, where he continued to work for the next 34 years. He obtained his Dip Orth in 1952 and was Orthodontic Consultant to the Eastbourne Hospital Group. He still found time to Chair the local LDC and represent the MOH Appeals Panel.

Over the years Roger gathered around him a number of fine young dentists and 'Felixholme' became one of the most respected practices in East Sussex. Reluctantly retiring (for apart from his family, work was Roger's greatest love) in 1984, he and Phyl went to live at 'Kepplestone' from where they had magnificent views of the sea from Hastings to Beachy Head. These last few years were probably some of his happiest, overlooking lovely gardens and able to indulge in a daily stroll along the prom.

As a friend of over thirty years, I mourn his death, as will his many colleagues, friends and patients to whom he gave devoted skill and care throughout his professional life. We shall miss this gentle and caring man.

To Phyl, his children Christopher and Helena (also a Guy's 'Man') his stepmother and all his family we send our sympathy on their sad loss.

GAW

Ronald Wilfred Willocks

Ron Willcocks BDS, FDS, D.Orth RCS died on Sunday 25 July 1993 after a painful illness borne with great fortitude.

He was known to many of us for the best part of 50 years--since he left the Naval service at Guy's Hospital in 1947. He had been commissioned into the RNVR and transferred to RN at the end of the war.

In common with all the ex-servicemen, who were collectively known as 'mature students', he made every possible use of the time and teaching offered to him and yet found time also to play Association Football for the Hospital.

He was an able man with a practical bent, whose orderly mind, manner and meticulous approach made him an outstanding student and postgraduate. His very evident caring nature and sympathy found its natural outlet in lending him to work admirably with children and to specialise in their care whilst at the same time maintaining an active interest in oral surgery under theatre conditions for children and some adults.

His hospital appointments commenced at Guy's, as House Surgeon and Registrar to Mr Rix and Mr Pringle, and led on to appointment as Consultant Orthodontist to Whipps Cross, Southend, Colchester and Chelmsford Hospitals. In this Area he was the pioneer and organiser of the hospital-based service in Orthodontics and dental care of children. It was here that so many came to know him and, indeed, sought to work with him during their training years for he could enthuse them with his knowledge and practical experience and management skills. In addition he was the Dental Postgraduate Tutor organising and participating in courses for general dental practitioners, some of whom he incorporated into his departments to work under his tutelage and gain experience. In his precious 'spare time' he managed a small but much appreciated private practice in orthodontics both in the West End of London and later in Epping, nearer to his home.

Valued not only in his own department he was an active and regular attender at staff committee meetings, and in his turn a positive and considerate chairman, always helpful and quick to understand problems raised by colleagues--which he handled with considerable diplomacy when necessary. An onlooker might say that his department appeared to be run as a 'tight ship', but none the worse for that. The immediate and warm welcome given to newcomers to the hospital staff went on into enduring friendships with Ron and Margaret. On retirement he instituted the very successful twice-yearly informal lunch-time meetings of retired consultants at Whipps Cross, and continued to run them until May this year, when a lesser man would have sent an apology.

However, his influence went much further than his practice and hospital appointments. His service on the council of The British Society for the Study of Orthodontics (BSSO) was one of orderly progress for no one was more meticulous than he in the Secretarial management of the Society's affairs and meetings, both professionally and also for so many years as the organiser of the Society's golfing events. His colleagues were glad to elect him a Life Member and also make him one of the earliest recipients of the Society's Special Service Award.

Such a balanced and generous and kind personality was also the focus of a

very happy family and all who knew him will join in extending sympathy to his widow Margaret and his children Elizabeth and Richard.

We are sad to have lost the presence of a joyful man, a proud man, a generous, honest and loyal friend with a sense of humour which he maintained to the end. end Who can possibly forget that gentle chuckle so often followed by, 'Quite so, quite so'?

Alan Campbell
Emeritus Consultant
Guy's Hospital

Our health-- the problem of neglect

Nurses are notoriously bad in caring for their own health and taking notice of the best way to promote it. 'Catering for others' is their motto. However, if you don't look after yourself, although others may recognise how you are failing in your duties, they may fail to identify specifically that this is a result of ignoring one's own best interests. Physical and psychological health are maintained in various ways, and not every individual has the same requirements.

The stresses and strains of modern life are brought about by a variety of pressures--nevertheless most studies have found that nurses drink and smoke more than is good for them, and also suffer back-strain almost as an occupational hazard!

Drinking is a pleasurable pursuit which most of us enjoy from time to time. Alcohol acts as a social lubricant, but many questionnaires have illustrated nurses' lack of knowledge about alcohol, it's action, it's consequences and the possibility of dependency. Certainly more education in this area is essential. I must put my own cards on the table. At the time of writing this article I was attempting to get a group of colleagues and friends together to attend that annual liberation, the Great Beer Festival, where real ale, and my favourite, real cider, is plentifully available. It's a great occasion, and provided consumption is limited, I may even remember how good it was! But dependency on alcohol, and the need for a drink to reduce depression, stress, or induce sleep, is the top of a dangerous slope. Once on the slope, some folk will never stand a chance of returning to the summit unless they totally refrain from the joys of Bacchus.

Smoking is an area I cannot speak about from a personal point of view. I must be one of the few people who have never succeeded in smoking one cigarette successfully. I have never seen the need for 'lighting up'--perhaps this extends from a fear of matches as a child! To refer back to drinking--at least everyone needs to take fluids in some form but smoke is

entirely alien to the human metabolic process. Why nurses smoke so much--and why are the 'new' smokers mainly younger? Well, the nurses have presumably slipped into the smoking network either before commencing training, or after, as a result of social group peer pressure. There is a plethora of anti-smoking propaganda now; the hospital has a no-smoking policy, as mentioned numerous times in the *Gazette*.

Many workplaces, and leisure areas ban smoking nowadays. This gives smoking, to the young and rebellious, who, wish to live an alternative lifestyle from what they're told is good and righteous. In the earlier years of this century it was considered impolite for women to smoke in public. Many women, who perhaps wished to assert themselves, found in smoking an outlet from the shackles of 'right' and 'proper' behaviour for a lady. I admire this, but unfortunately, we have fairly certain knowledge that smoking is injurious to the good health of both those who indulge personally, and those who are affected by inhalaltion of fumes 'passively'. Smokers even have their own protective organisation known as FOREST. I have always thought this acronym should read--Forget Other's Rights to Enjoy a Smokefree Terrain. This is a difficult cause to address. Being a life-long non-smoker I have never felt as strongly against smoking as many ex-smokers. True, I am pleased that there is a no-smoking rule on buses and trains, but I don't mind smoke whirling round my head in a pub. Make what you will of that!

Back pain, though a greater problem for nurses, is easier to address. Much of it occurs through improper training, or at least improper practice, when training has been given. It often seems easier to take short cuts. Most of us do ignore admonitions to good health.

An interesting aside about health is an approach I heard about recently. What, if nurses and other staff, only received pay during sick-leave if this sick-leave was certified absence for broken legs, hearts etc? Then, the odd day off, here and there for the minor ills which seem to afflict some, but not all, would be subject to a deduction from pay. Would this see a rapid decline in absenteeism through sickness? Would giving up smoking and drinking help?

In my last piece in these pages I quoted Sister Relihan's record of over fifty years without a day off through illness. Perhaps I should declare a personal position, a lot poorer than this: no days off sick for more than ten years. Maybe I should be wary--pride comes before a fall, except in the dictionary. But I do believe thinking fit will help us all to keep going.

Denis Cobell

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Nam-Pai-Chuan--the way ahead

We are one of the styles in the vast panoply of Chinese Martial Arts. The system was brought to England by Sifu (instructor) Christopher Lai from Malaysia in 1977. Since then Nam-Pai-Chuan has grown from strength to strength and is now well-established in the UK and Europe. Currently we have over fifteen centres in London (at ULU, Imperial, LSE to name but three) and are planning to develop a centre at Guy's.

Nam-Pai-Chuan has a very rich weapons and forms heritage; eighteen traditional weapons and over fifty different forms. It also embodies many techniques such as self-defence, kicking, punching, locking (Chi-Na), breathing exercises (Chi-Kung), throws and nerve-point use. In addition we have styles based upon the various animal forms prevalent in Chinese Martial Arts.

We are a member of the British Council for Chinese Martial Arts (BCCMA) and the Martial Arts Commission, the controlling body for Martial Arts in the UK.

As well as training and learning NPC techniques, members participate in a number of inter-centre events ranging from ice-skating and social dinners to demonstrations of NPC.

You are welcome to join in or watch our training sessions--Wednesdays 6.00-8.00pm, Pavy Gym, Guy's. The first lesson is free and we look forward to meeting you.

Sebastian Chung

The rugby review

Grease took 3 solid months rehearsal in the West End Dominion to be ready for public consumption. Even God took 7 whole days to complete his masterpiece. However Guy's Hospital RFC ignored such precedents and indeed took the theatre world by storm. Fighting against the elements of revision, the workaholic ethic and the alcoholic ethic, our six rehearsals were attended by as many people. Undaunted the director and his trusty troupe pressed on amid flamboyant outbursts, tears and thrown teddies. Darlings it was like Thursday nights in winter at Honor Oak Park.

The opening night

The first time the entire cast were together. I felt at one with the blind shepherd and his three-legged deaf collie. This was it. The one and only rehearsal and dress rehearsal rolled into one. Tiffs, locked waists and luvvies were in abundance. Fortunately some of the acts had got themselves together prior to the 'performance'--most gratifying and more than evident on the night. Well done Harry.

The opening obscene was provided by the 2nd XV, led by Jonny Spencer. The additional member was supplied by Greg--the amazing purple patella basher. Further bodily functions were then performed by the 'chips and gravy' duo George and Jon, who were certainly well-oiled in plenty of time for the show.

Physical theatre came very much to life as wigs, suspenders and make-up were hunted down and donned by the boys. The actors had much trouble finding their props and costumes in the dark cramped wings, resulting in an experience not to

be missed--when the four Yorkshiremen sketch became the one Yorkshireman, accompanied by two Welshmen and a Spaniard.

The oldest rugby club in the world is not without certain traditions, among them the imbibing of turnips and lyrical creativity. Lloyd-Webber has nothing to compare with 'Nina-The-Cleaner', a rendition which allowed Skyrrie's and Pryke's hidden talents to shine. The musical flavour continued when duets became quartets as Roy and Steve Lewis assisted in the 'Sexual life of various Guy's People' song. This led hazily to the interlude where the moving waiters involved the audience in the 'Tequila Song'. There's nothing like a bit of audience participation!

Next came Prof. In the world of Dentistry, Steve is highly respected and brilliant. As our president he is much loved and is equally hard-working and brilliant. Prof did a poem.

Moving swiftly along next came the colourful sketch for insomniacs in the audience--the irony, wit and intrigue of the 'Traffic Lights Song.' Backing vocals were provided by the Bermondsy Angels--Tank, Breezy, Mat, Bitty and Skyrrie and lighting by Freddy Filter and the Sweet Wrappers.

Among the unforgettables but unmentionables were the running themes of the night. Dan's hand shandys and of course Joyce's Pantry. But the show at HOP was stolen by the appearance of 'Roy and Hairbear'. Jon and Pitt-Pony obviously leading double lives.

And so the first Rugby Review went off with plenty of hiccups--all accredited to the bar. The atmosphere was brilliant thanks to the audience and the commitment of Guy's 1st-5th XVs. This created a fantastic night of fun which raised a lot of money for the memorial funds of James and Alex. The evening was rounded off fittingly in their memory with a barber shop harmony from Ben Wayne, James Gushy and Dipper, followed by the entire cast singing 'Rolla-Rolla.'

Many thanks to everyone who played a part, big or small, especially those on the door, such as Simon and Baldrick. What a great night! Watch this space for the Christmas show.

The oldest rugby club in the World

GHRFC 150th Season

With the start of this historic period looming it is time to dust off your rattles, scarves and boots and support in any way you can. The season opens for the 1st XV on September 4th with a tough game against London Irish. This should set the tone for us all as the fixtures are for more competitive and testing this year. Training is well under way at HOP and Nigel expects to welcome many faces, old and new, on Thursday nights at 6.30 pm. Our aims and expectations are high this season as the club strives for promotion in the League . For the 1st XV victory in the Hospital's Cup in the 150th Season will taste so sweet, whilst our 2nd XV of course expect to retain the Junior Hospital Cup and set in motion another spate of consecutive victories. Once again we are running five teams at Guy's. Come join and enjoy the season.

Patrick Gush
PR officer GHRFC

GHBC--ladies'

Marlow Regatta

Following the outstanding success of the winter and spring terms, the summer was eagerly anticipated by all members of the ladies' club.

Throughout the spring on those cold early mornings, the size of our sailing squad had dramatically increased and standards improved under the watchful eye of Alec Hodges. By the beginning of the summer term we felt ready to enter our first Amateur Rowing Association event--a double sail at Marlow Regatta. At first it looked as if we would be unable to compete at all, having no boat of our own and unable to borrow one. Luckily, with only a few minutes to go we were lent a boat by Marlow Rowing Club. As no other novice boats in our clan were entered, we were forced to row in the class above, and made it through to the final.

Despite splendid support from the towpath and a good start, we were unable to hold off the double from Kingston (the crew that was to make the final round at Henley later in the season!) but to finish 2nd in Seniar 3 double sails in our first event was ample prize for us.

Crew: Louise Ward, Vanessa Parmetre

London Docklands' regatta

This prestigious event took place on 5-6th June over 1750 m, at the Royal Albert Dock. We entered our IV, which had been coached over the summer by Alec Hodges and were eager to test ourselves against opponents from further afield.

Racing in temperatures of more than 90F it certainly was a test. On Saturday we won a silver medal, beaten narrowly by Imperial College--our old rivals. This was the first medal a crew from UMDS had won in the regatta.

On Sunday we returned to do even better, winning college IV's--beating the top Oxbridge college, Sommerville and finally proving that women at UMDS can row.

Crew: Emma Helen (cox), Olly Foote, Louise Ward, Vanessa Parmetre, Sharon Payne, Amanda Bowman.

Bumps

After Marlow, sailing had to take second place to rowing for a while, as preparation for the bumps began.

The event took place over 3 days, 17-19 May and as UHBC, we were not only competing, but running the whole event. The five previous GHBC ladies' crews were now competing under the names UMDS 1 and 3-6 in the positions of the old Guys and Tommies crews.

White-water conditions for division 1 and a late afternoon storm on the first day caused the only upsets in otherwise perfect weather conditions for all 3 days. Andy Klein and Mike Rocker managed the event superbly from UL, giving spectators a live commentary on the races further up the course and the latest bargains at the T-shirt stall, capably managed by Kate Scanlon and Millie Lear. With John Crossman in control of the races from a launch, we were able to concentrate on our rowing.

All crews did their part in securing 2nd place for the best overall performance by UMDS.

The Novice B crew, unfortunately placed behind the Senior 3 Kings Ist boat, rowed over and got their well-deserved bump on the last day.

The Novice A crew fared better, bumping all 3 days to win their blades. On the last day they held off the Kings boat long enough to catch UMDS 3--a well-deserved set of blades for a crew who has shown such commitment and talent all year.

The 2nd VIII held their position well, going down on the last day.

After only 2 practice outings, the 1st VIII was in peak condition. They stayed hot-on-the heels of St Bartholomews all down the cruise, waiting for the right moment to bump--outside UL. Not only that but, to further shame Barts, we were the only 1st crew in fancy dress ('amalgam-eight'). We finished at position 3--the highest position of a ladies crew for a very long time.

Crews: 1st VIII: Mo Roy (cox), Louise Ward, Vanessa Parmetre, Sharon Payne, Michelle Roberts, Emma Parkinson, Ruth O'Sullivan, Dany Power, Julia Thomas.

2nd VIII: Caroline Child, Julia Shaw, Debra Harper, Arabel Sonerville, Noomi Sweeter, Sona Biswas, Dominique O'Leay, Ruth Selwood, Philippa Rust.

Novice A: Rob Huggart (cox), Monica Dandelier, Kathryn Meickle, Jane Neehin, Zoraine Fisher, Claire Emery, Hannah Lord, Nina Burrows, Micola Ballard.

Novice B: Ollie Foote, Sinead Buns, Anna, Kate Scanlon, Jane, Millie Lear, Clementine, Anita Barnwal, Helen Rogers.

Louise Ward

Rifle Club

For the first time in four years, the Rifle Club entered *students* into this years United Hospitals (fullbore) at Bisley. Recently, we have been relying on teams consisting entirely of 'Old Boys' to make our presence felt.

After a couple of practices at Bisley, a small band of 'merry assassins' was formed--with Mike 'Tubbs' Osborne and Guy 'Dentures' Palmer leading a particularly strong group of novices.

After a friendly match against the London Hospital (which UMDS won overall by a single point) we were gaining in confidence. The run of luck held out when we survived a road block stop and search--being only mildly hindered by Palmer acknowledging to the (armed) Met. Police that he was not sure if he was carrying weapons or live ammunition through the City of London. Perkins saved the day by showing his UMDS library card as our means of identification.

Unperturbed, we entered the UH Cup on the 16th July. It was now that 'Hawkeye' Lewis let loose his two secret weapons (cunningly kept under wraps by the guise of revising for part 1 MBBS). Will 'Chalky White' Fellingham and Billy 'The Weapon' Challacombe were unveiled to the terror of the other teams. The second year was represented by Dan '3-Fingers' Perkins, Simon 'Wing Attack', Hughes and Nicki Cohen.

The return of the UH Cup to UMDS was the best way to end our most successful season ever. We hope to be on target again next year and welcome anyone interested in joining.

Keir Lewis (sec)

Ladies hockey

The 'liquid' tour squad

The 1992-3 season was not one of our most successful but was nevertheless throughly enjoyable. The league performances of the first team were rather variable as we could only seem to beat those teams that were better than ourselves. However things improved a bit in the second half of the season when several players returned home from their electives and various injuries had finally healed. The seconds meanwhile were having a more successful season in the league and managed to finish third. Unfortunately the league system has been changed and somehow they have hone down a league, much to our annoyance.

The high point of the season was reaching the semi-finals of the UL cup where we met King's College, who were unbeaten in the league. The half-time score was 2-2 and we felt we were in with a chance, even though we were the underdogs. However King's went into overdrive in the second half and their rather superior fitness told. The final score was 9-3 and King's continued on to win the final.

The season ended with a very 'liquid' tour to Dublin, over the Easter weekend, with the men's second team and Southgate Hockey

Club. Many thanks to Penny for organising it yet again.

Hannah Reece-Jones

Guy's Hospital MEMORABILIA

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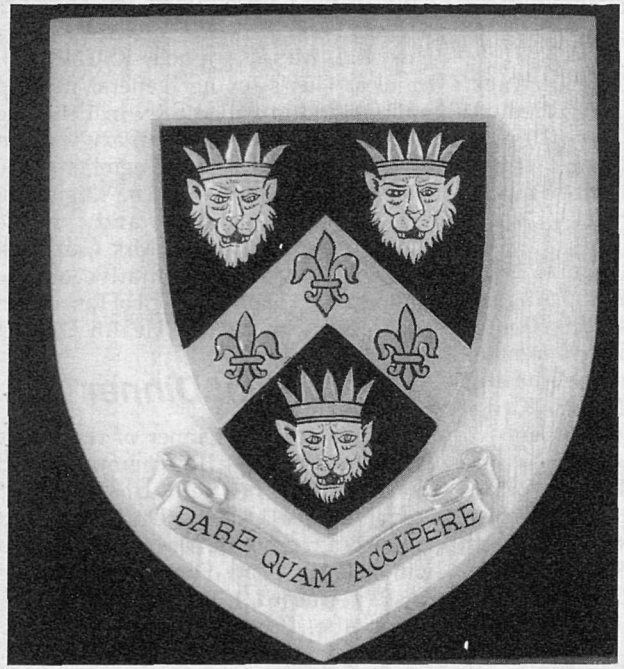

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Deaths

TUDGAY, Doreen (nee O'Neill), died peacefully at home on 13 September 1993. Guy's nurse 1948-52.

POWNALL, Dorothy Rosemary (neé Bulmer) SRN SCM, Guy's 1953, died on 25 July 1993, after a long illness, courageously borne. Loved by her family and dearest friend of Margaret Francis (neé Cole).

FAWCETT, Angela R (neé Fooks) LDS, DiP Orth, RCS, 20 April 1929 to 7 August 1968. After being the first lady house surgeon at Guy's, in 1952, Angela went to the Eastman, before becoming Orthodontist to the Hong Kong Government and subsequently to Wiltshire County Council.

She is remembered with love and pride by her brother Professor Allan Fooks (Guy's 1946) of Tufts, Boston, USA, her husband Michael (Guy's 1952) and their children Jane, Peter and William (Guy's 1985) on the 25 anniversary of her untimely death.

'Well done, thou good and faithful servant'.

BA

Dr W G Cross (Guy's 1934-42) BDS LDS MRCS LRCP MBBS MS has recently obtained BA (London) in French with Italian as a subsidiary subject.

Birthday Honours

Mrs Margaret L Campbell was appointed MBE in the Queen's Birthday Honours list on 12 June 1993, for services to Guy's Hospital. Mrs Campbell, RSCN 1943, came to Guy's for her general nursing training and qualified SRN in 1946. She has been involved in voluntary work at Guy's since 1966, being a member of the Executive Committee of The Friends of Guy's since 1975 and made Vice-Chairman in 1988. Mrs Campbell was the Guy's representative on the Community Health Council of Lewisham and North Southwark Health District

Annual Dinner

The 38th Annual Dinner of the Guy's Hospital Society, Bournemouth and Wessex will be held on Friday 5 November 1993, at the Durlston Court Hotel, Bournemouth. Mr D M McDonald will be in the Chair. Further details from Mr E H Archard, 1, Beechwood Avenue, Boscombe, Bournemouth, BH5 1LX. Telephone 0202 393077.

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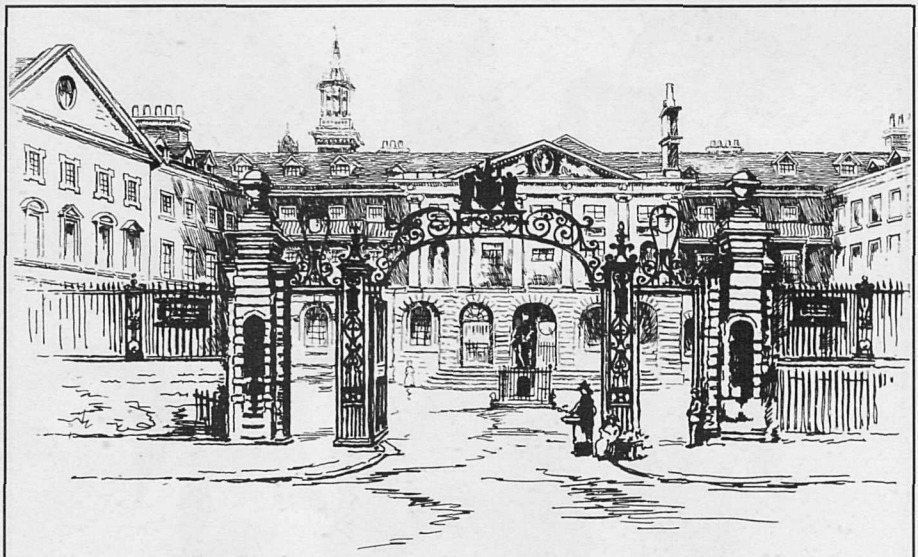
November 1993

- Trust Board's decisions
- Quackery versus rational therapeutics
- GHRFC—150 years festival day highlights

Seasons Greetings



Christmas Greetings

All here at the Gazette,
would like to wish our readers
a very

Merry Christmas

and

Prosperous New Year

CONTENTS

314 **Passim**

315 **Gazette Letters**—Inadequate facilities

317 **Gazette News**—Radical changes

320 **Gazette Feature**—Quackery versus rational therapeutics

328 **Gazette Feature**—Out of the Frying Pan...Life as a HO

331 **Gazette Feature**—Windsurfing extravaganza

334 **Gazette Feature**—Communications and learning

336 **Gazette Feature**—Project ORBIS

340 **Gazette Reviews**—Pharmacology

342 **Gazette Obituaries**—Donald Leeming, Julian Mountfield, Peter Lommerse

344 **Nursing Notes**—Strike!

347 **Clubs Union**—Rugby review

350 **Sport**—Netball, sailing, rugby

356 **Classified and announcements**

UMDS Guy's
-5 JAN 1994
Wills Library

Guy's Gazette

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Passim

First and foremost an apology for the sparse supply of Gazettes in recent months. The reason for this is two-fold—an elusive computer fault, finally located to the power-pack and pathology finals. The former is, after a succession of new 'mice' and bemused computer engineers, finally repaired. The shadow of the latter still lurks—as I write vivas and the results board are yet to come. The pathology lecture course has, in the main, been absorbing and interesting and its clinical relevance is self-evident. However it is a great shame that the sheer volume of work forces extra-curricular activities, especially those requiring 'mental exertion' to one side. The time-tabling of the pathology lecture course is one of the alterations in the new 3rd year curriculum. It is to be an extended course, covering both basic and systemic pathology at the end of the first clinical year.

This replaces the previous system of quartiles in between basic and second block pathology. Whether this facilitates learning or deprives students of valuable clinical experience, upon which to mould their understanding, is to be seen. However, one thing is certain, an extended course, at the same pace as block two pathology, will be tough—but not, I am assured, as exhausting as finals. Best of luck to those returning back from their electives.

The main news from the hospital front again concerns the Trust Board—a phrase becoming synonymous with the word 'change'. The Board has decided to retain both sites (see Gazette news for further details) and is investigating the possibility of a minor injuries service on the Guy's site. How this will fit in with the patterns of A and E self-referrals of the local community and also the clinical services that remain on the Guy's site remains a matter of speculation.

Will a minor injuries service be seen as an 'easy-access, 24 hour' GP or will the concept of a hospital being for all emergencies still hold? Also if the A and E department at Guy's becomes a minor injuries service this will require a degree of re-organisation of clinical teaching. Referrals from A and E and nights 'on-take' in casualty provide invaluable 'on-hands' clinical experience and a diversity of cases to learn from.

The Trust Board is awaiting the Secretary of State's response.

Cycling

Dear Sir,
Orna McGinn's article on cycling in London makes depressing reading for your older graduates. In 1936 as a pre-clinical student I lived in digs in Paddington and would cycle to Guy's most days of the week via Hyde Park Common, Westminster Bridge and The Cut. If I went in on a Sunday I would challenge myself to complete the whole journey without touching the handlebars. The greatest hazard was not the traffic but the tramlines. South of Westminster Bridge there was a complex point system which necessitated particularly violent swerves to avoid having ones wheels caught in the grooves.

Road surfaces also were poor, the warehouse area through which the Cut passed being particularly bad.

However, roads were free of double yellow lines, in fact of any lines, Traffic Wardens, compulsory helmets, safety belts and all the apparatus of the Nanny State. Happy Days! Actually the casualty rate per vehicle was horrendous compared to today.

Yours faithfully,

P N CARDEW
East Stoke
Nr Wareham
Dorset

PS On second thoughts what was I doing as a pre-clinical student in Guy's on a Sunday morning?

Cardphones

Dear Sir,
Although I have suspected it for some time, it was only a few days back that I managed to confirm that there are indeed no 'Card phones' left on the Guy's site. All the public telephones have now been replaced with coin operated pay phones.

What I had come to expect of trust status was income generation schemes and convenience for staff and the public. Whilst these new telephones may satisfy the former, it certainly doesn't help the latter. Might I suggest that the originators of this idea have the telephones in their offices replaced with the new Guy's pay phones!

Yours faithfully,

FUAD HUSSAIN
Boland House

Dangers of dehydration

Dear Sir,
I would like to reply to the recent notice by Professor Chantler about the vandalism of lecture theatres. Although we all deplore vandalism, I am sure most of the damage was accidental and unfortunate. These incidents only seem to highlight the inadequate facilities. The Tower lecture is presently too small for the 220+ pathology students. Students have to sit in the aisles; this is both a fire risk and uncomfortable. Also, with numerous lectures during the day, the 15 and 30 minute breaks are too short to allow students on the 30th floor of the Tower to get to refreshment facilities in the Spit. Bringing refreshments into the Tower is the only solution.

The Prideaux lecture theatre has probably the worst acoustics and audio-visual display facilities of any theatre designed, making it an impossible place to lecture, for both students and staff. The Nevin, although very nice, with improved audio-visual display facilities and a great improvement on the old Nevin, can get very, very hot, especially after six hours of lectures. Why isn't an adequate air-conditioning system used to make the atmosphere comfortable? No wonder students bring drinks into the Nevin. They have obviously learnt the dangers of dehydration from their chemical pathology lectures.

Changes within the Hospital and Medical School require compromise,and it is to be hoped that the Medical School adopt a more 'user-friendly' attitude to timetabling of courses to make our learning experience more enjoyable.

Yours faithfully,

RICHARD PROBERT
Boland House

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Radical Changes at Guy's and St Thomas's

The Guy's and St Thomas's Trust Board met on 4 November 1993 to review its future strategy on the distribution of services between the two hospital sites. The Board's conclusion was to retain parts of both the Guy's and St Thomas's sites but radical changes are planned in the services provided on both sites.

The Trust Board recognised that a single site solution for in-patient clinical services was favoured by clinical staff; such a solution, if fully funded would be possible on either site. However it was equally recognised that General Practitioners and the community strongly favours the retention of both sites. In addition, the Board believed that the capital funds to achieve a single site solution were unlikely to be made available or guaranteed at this time.

In view of the likely constraints on capital spending, the Board concluded that both sites should be retained for the provision of clinical services but with significant change in their current configuration. It is proposed that the Accident and Emergency Department at St Thomas's should be retained while the possibility of a minor injuries service on the Guy's site will be investigated by the Board.

It is planned to use the best buildings on both sites for health care including, in particular, the clinical use of Philip Harris House as near as possible to that originally planned. The reorganisation of services will be guided by the need to ensure clinical coherence and a high standard of care for patients. The Board intends to make available to UMDS and King's College
space vacated by the rationalisation of services so that basic medical, dental and nursing education, along with research in basic medical and life sciences can be consolidated on one site.

The Trust's recommendation and proposals will be considered by the Secretary of State, the London Implementation Group and by the districts who purchase services from the Trust. Following the Secretary of State's response, there will be a period of consultation on the specific changes in services before final decision are made.

The End Of Dissection?

Doctors and software specialists have developed an interactive computer program, using thousands of coloured pictures and graphics, to teach Human Anatomy. ADAM (Animated Dissection of Anatomy for Medicine)--or EVE as it is termed when it covers female anatomy--allows the user to 'dissect' the human body, layer by layer; each area can be viewed from the back, front, side or in cross-section.

The program has been on the market for about a year, and is already very successful--about 50% of medical schools in the USA use it for training in dissection. Other applications include simulation of operations, and explanation of procedures to patients.

ADAM recently became available in the UK. It remains to be seen how widely the program will be used here--and whether that familiar odour of formalin from the dissection room will become a thing of the past.

Caroline Walker Award

Professor A J Diplock of the Free Radical Research, UMDS, Guy's hospital, received the 1993 Caroline Walker Award for Science from the Caroline Walker Trust, at the Royal Society, on 24 November 1993.

The citation is, 'For distinguished work on the health effects of anti-oxidant nutrients'. Professor Diplock accepted the award on behalf of himself and co-director, Dr Catherine Rice-Evans and the members of the Free Radical Research group, as well as, 'For the huge number of medical scientists worldwide who are undertaking research in this key area'.

Surgical Careers Day

A Surgical Careers Day for medical students, House Officers and Senior House Officers will be held on Thursday 13 January 1994, at the Royal College of Surgeons of England.

The day's programme will include talks on the role of The Royal College of Surgeons, surgical training, examinations and qualifications, and careers in the surgical specialities. There will also be an opportunity to look around the College's library and museums.

There is no charge for attendance at the event and further details can be obtained from: The Department of External Affairs, The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London, WC2A 3PN. Telephone 071 405 3474 Ext 4173.

London Marathon 1994--For Guy's Kids and Kidney patients

During 1992 and 1993 London Marathon runners raised a total of £183,409 in sponsorship jointly for Guy's Evelina Children's Unit's 'Sponsor A Cot' appeal and Guy's KPA's '£750,000 appeal' for kidney transplant research at Guy's.

Both of these appeals are still ongoing and urgently need to recruit runners with places in the 1994 London Marathon and collectors prepared to collect for the appeals on the London Marathon route on Sunday 17 April 1994.

Anyone interested should contact: Lisa Anderson, Secretary, Evelina Appeals Office, Henriette Raphael House, Guy's Hospital, St Thomas's Street, London SE1 9RT. Telephone/fax 071 403 4089.

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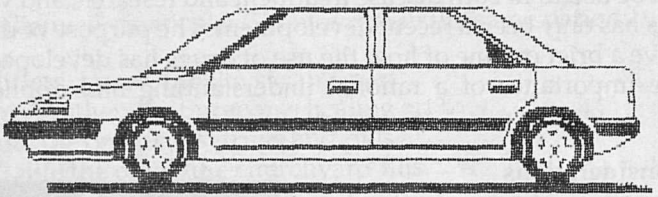

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Quackery versus rational therapeutics

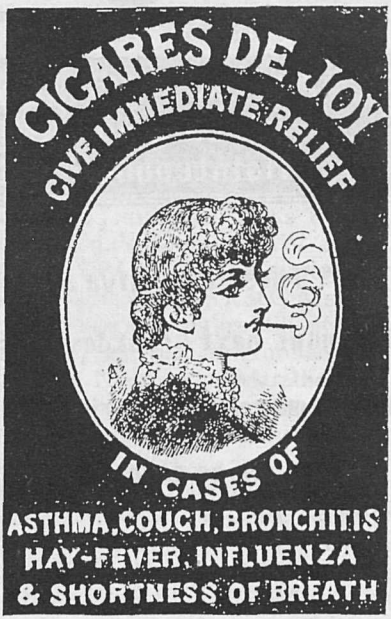
The useless versus the useful

The WHO defines a drug as „any substance or product used or intended to be used to modify or explore physiological systems or pathological states for the benefit of the recipient'. It is implicit in this definition that drugs should be useful in both disease treatment and research, and yet for the most part this has only been a recent development. The purpose of this article is to try to give a brief outline of how the use of drugs has developed, and to highlight the importance of a rational understanding and application of therapeutics.

Historical considerations

For many years, medical understanding of body function was largely limited to gross description, with disease considered the result of, 'the evil influence of an enemy, a demon, a god or even an animal'.[1] Subsequent to this, disease was believed to represent a disequilibrium between the four bodily fluids-blood, phlegm, choler or yellow bile, and melancholy or black bile, which made up the 'humour'. It was this latter concept of disease that led to the widespread use of such treatments as vomiting, purging and blistering, and it is interesting to note that even at this time the apparent success of these treatments was used to support current medical beliefs.

Consider one example published in *Philosophical Transactions Of The Royal Society* in 1667, concerning the supposed value of the emetic Ipecac as, 'an infallible Medi-



cine for curing Dysenteries by disposing ... by Degrees for Purging, and to sweeten and correct the sharp ... Humours, which are the Nature of Aquafortis [Latin *strong water*], and the Spirit of Nitre [nitric acid], and which eat away the Tunicles of the Intestines, and the Mouths of the Vessels'.2 A similar report concerned a delusion on a ship at sea, 'He began to admire the fine Woods, which he fancied to be near us. A Vomit of (induced by) Antimony...and...all those Imaginations vanished'.

This ignorance concerning drugs and disease was reflected in contemporary comments about physicians. John Webster in *The Duchess of Malfi* (1613), for instance, wrote:

She'll use some prepared antidote of her own,
Lest the physician should re-poision her

Maximilianus Urientius of Ghent wrote in the same period:

How differs, I pray, the Physician's part
From his brother, the Surgeon's healing art?
I tell you, the one by his drugs and pills,
By his knife the other, the churchyard fills.

Finally Voltaire (1694-1778) stated that a Physician 'is one who pours drugs he knows little into a body of which he knows less.'

Emergence of quackery

Partly as a result of these beliefs, advertisements for quack medicines became commonplace from the late 17th century onwards, claiming remarkable new discoveries and unfailing success, but most were noticeably secretive regarding the components and mechanisms of action of these medicines. Some illustrative examples of these advertisements have been reproduced for the reader's entertainment.

Two reports published by the British Medical Association in 1908 and 1912 heavily criticised these 'wonder cures', and provided analyses of remedies available at the time in an attempt to, 'contrast the claims and exuberant boasts of the vendors ... with the banal ingredients.'[3,4] One example was Rice's treatment for 'rupture' (hernia), the advertised description of which read as follows:

'Do you see this bricklayer closing up the opening in that wall? That is the way to cure *rupture*, by filling in the opening with new and stronger tissue.

A rupture is simply a break in a wall- the wall of *muscle* that protects the bowels. It is just as easy to cure a wound or break in *this* muscle as one in the arm or hand.

We give you a Developing Lymphol to apply on the rupture opening. This penetrates *through* the skin to the edges of the opening and removes the *hard ring* which has formed around the break.

Then the *healing* process begins. Nature, no longer handicapped by the protruding bowel and hardened ring at the opening, and stimulated by the action of the Lymphol, throws out *her* supply of lymph, and the opening is again filled with *new muscle.*

Isn't this simple? Isn't it *reasonable?'*

Despite these remarkable claims, Rice's treatment comprised nothing more than tincture of capsicum, oil of peppermint, and oil of spearmint. Other typical 'medications' of this time included soothing syrups containing opium, face preparations containing arsenic and zinc oxide, stomach bitters made with whiskey, health restorers containing narcotics, and specifics for rheumatism containing red pepper, licorice and sugar.[5] As one might expect, these treatments were generally ineffective, save for a placebo effect, and in some cases could be dangerous.

Quackery versus rational therapeutics

Not all early treatment rationale were inconsistent with modern concepts of disease, however, such as one treatment proposed for dropsy in 1667, 2 'Take Morfus Diaboli, and put it over the fire in a dry Kettle, that it may wet only with its own Juice, and of this to apply a Quantity to the Belly and Reins of the Patient, covering him up warm, to so provoke sweat; which will come away in great quantity.' In this case, the 'drug' is likely to have been irrelevant to the treatment's efficacy, which probably resulted from the induced sweating, and consequent fluid load reduction.

As regards true 'rationalism' in the use of drugs, one of the earliest and best examples is digitalis. The term digitalis (Latin *digitus,*

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Mrs. Scott's word of gratitude is only one of hundreds in possession of this company. Anyone who will send their name and address to

THE EUCRASY COMPANY,

62 Hunter Street, Sydney, will receive by mail, sealed, a free book about this wonderful remedy, and full instructions how to cure the drink habit.

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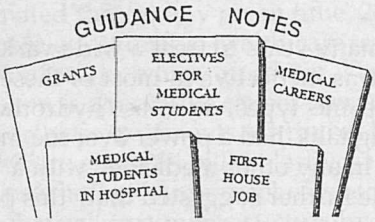

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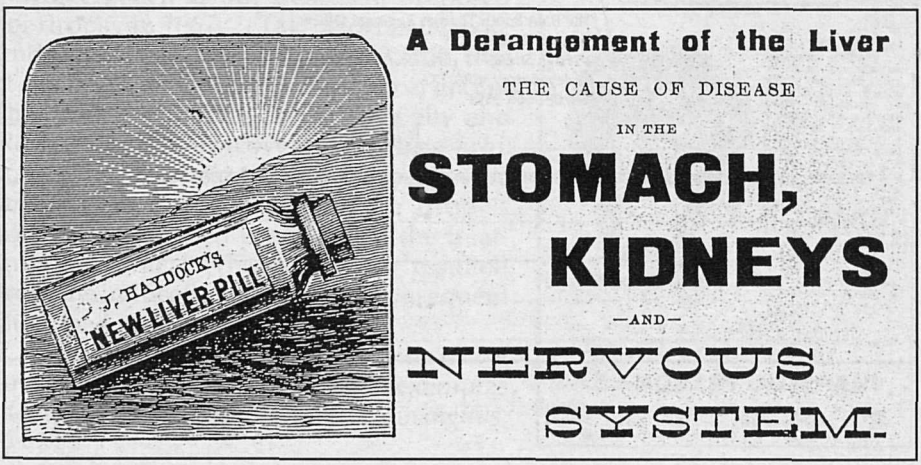
finger) was first applied to the foxglove by the Tübingen botanist Leonhardt Fuchs in 1542,[6] but it was not until 1785 that digitalis was rigorously investigated by the Birmingham physician William Withering, who found a secret folk remedy to be composed of, 'twenty or more different herbs; but it was not difficult for one conversant in these subjects ... that the active herb could be no other than the Foxglove.'[7]

*Digitalis purpur*ea had been used for many years to treat a wide variety of diseases, but Withering showed that it was ineffective in most of these, and even in dropsy was only effective in some types, such as 'hydrothorax'. Mechanistically, Withering noted that digitalis 'had a power over the motion of the heart to a degree yet unobserved in any other medicine,' with a 'slow pulse, even as slow as 35 in a minute.' He further suggested that, 'this power may be converted to salutary ends.' Despite the fact that 'evacuation of the water' by means of increased urine production was considered by Withering to be the primary mechanism of action of digitalis, his and later observations of the cardiovascular actions of the drug have clearly contributed to both the treatment and understanding of dropsy and heart failure.

A turning tide of opinion, development of the medical sciences, and increasing legal restrictions forced the decline of quackery between the mid-19th and early 20th centuries. It is no coincidence that this was a time when the emphasis of medical practice was shifting from empiricism to rationalisation, with an increasing consideration of pathology and the modes of actions of drugs.



Nevertheless, quackery is far from dead, and remains an active source of debate in the medical literature.[8-12] The US Congress has determined quackery to be the most harmful consumer fraud against elderly people, and Americans have been found to spend some $27 billion annually on questionable health care, exceeding the amount spent on biomedical research.[11] Indeed, it has been estimated that, at any given time, 26.6% of the American public is using one or more questionable health-care treatments.[11]

One area in which quackery is a particularly disturbing (and increasing) problem is alternative cancer therapy. Spending by Americans on unproven or worthless treatments for cancer has increased from $100 million annually in 1965, to about $4 billion last year,[10] such treatments including behavioural and psychological approaches, special diets, coffee enemas, herbs, and 'pharmacological' treatments such as hydrazine sulphate, Laetrile, and vitamin C. While proponents may claim that these treatments are unconventional, and as such shunned and underutilised by doctors, Durant has pointed out that, in fact, none are unknown to the medical profession, and all have been studied.[12] It is a moot point that if any of the alternative 'treatments' had shown promise, the pharmaceutical industry, which is so eager to exploit new therapies, would surely have done so. So seriously is the threat of quackery taken in the United States, that the American College of Physicians has issued a *Position Paper on Health Quackery* (February 17, 1989), emphasizing the physician's responsibility to become informed about health quackery, and to disseminate this information to patients and colleagues. To this end, the US National Cancer Institute has instituted a freephone telephone number through which information regarding unproven cancer treatments can be obtained.

Interesting observations regarding the consequences of health quackery in developing countries, where it is endemic, have been made by Einterz,[9] and serve to emphasize the importance of keeping a tight reign on quackery in the West. These consequences include: the squandering of meagre incomes; delay in instituting proper treatment; and the debilitating side-effects of powerful drugs and injudicious interventions.

Concluding remarks

In conclusion, the prevalence of quackery in the developing world, and its continued costly persistence in the West, indicate that it still poses a major threat to rational medical science and therapeutics, not to mention the dire consequences for patients already alluded to. This threat has been eloquently summarised in a poem by Crabbe (American Medical Association, 1912):

'No class escapes them- from the poor man's pay
The nostrum takes no trifling part away:
Time, too, with cash is wasted; 'tis the fate of
real helpers, to be called too late;
This find the sick, when (time and patience gone)
Death with a tenfold terror hurries on'.

A quotetation from H L Mencken is even more to the point, 'for every complex problem there is a simple solution... and it is wrong'. Left to its own devices, one wonders where quackery would stop!

In summary, therefore, I would propose that the threat posed by quackery should not only be actively guarded against, but should become a subject of much more intensive research in the UK. Despite the fact that quackery first appeared in this country, it is depressing to note that most of the research discussed in this article has emanated from the United States.

John S Gilbody

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Out of the Frying Pan...

Into the firing line

All too quickly following the gruelling examinations, August 1 arrives and it is time to mature from student to doctor. The halcyon days of wandering into the hospital at midday and then musing whether to see a patient, or enjoy a few beers, are not to be recaptured for the ten or fifteen years that it takes to become a consultant. Now you are a doctor--it says so on your badge (next to the dreadful photograph) and you have a certificate from the GMC to prove it. Finally you can help people, just as you said when you described your vocation at the interview for medical school all those years ago. Suddenly, it does not seem a good idea.

Nothing can truly prepare you for life as a house officer. The only thing that I remember from my pre-house job was a registrar saying, 'the more that I practise medicine, the more I realise how easy it is to kill a patient.' It was not really what I had hoped to hear as I embarked on a life in medicine.

Idiosyncrasies

It is vital that you meet your predecessor and learn about your consultant's idiosyncrasies. It would also be very useful to dog his or her steps for a few days to learn the working s of the X-ray department, operating theatres, bed bureau and various other offices in which large parts of your day will be spent. Ultimately, of course, you have to experience it; no-one can teach you how to persuade a radiologist that an ultrasound is urgent (your consultant will consider all such investigations to be urgent), how to find missing X-rays, or how to find patients a bed.

It is astonishing that five of six years of intermittently intense study can leave one so wholly unprepared for the actual demands of the job. This is not necessarily a failing of the system since I, at least, have not been able to define what the role of house officer entails. If it were advertised like any other vacancy, then the job description would surely run into pages. However it must be said that the routine life of a house officer involves very little medicine; the house officer is the facilitator, ensuring that investigations are booked, that results are found, that notes are up-to-date, and that patients were discharged. One's usual day requires only occasional recourse to the

stethoscope or to the preceding six years of study. This is not the case when one is 'on take', and it is then that the difference between life as doctor and as student becomes most apparent.

On take

As a doctor you are now in a position of responsibility. Decisions now have to be made, and not just mulled over. One's time in casualty is easily the most interesting part of the job. Now you can start to use all those years of training in the diagnosis and treatment of patient's ailments--you begin to feel a useful member of the team, rather than simply a clerk. Unfortunately being 'on take' does not only involve working in casualty; there is the dreaded 'second on' during which one is responsible for the patients on the medical wards.

This is especially arduous during the weekends and usually starts by having to take blood from every in-patient (at least it often seems like every patient) before midday. If the bloods are not at the labs by that time, then they are not done unless you have telephoned the technician and requested every test personally. This seems a reasonable request until one actually spends a weekend as 'second on', then you realise that it is not simply a question of strolling onto the wards and then exsanguinating the appropriate patients. Oh no, at weekends the arrival of a white coat on the wards generates an endless list of tasks, all of which must be completed *at once*. There are usually a few patients 'that need reviewing', another that has not passed urine for three days, and another about which they are 'just not happy'. And, of course, taking the blood is not the end of the story, you still need the results. It is rare to have more than fifteen or twenty minutes respite between bleeps at the weekend, and any such intervals are spent trying to extract the results from the computer. I need not remind readers that the Law Of Sod dictates that the most wildly abnormal results will be the last to return.

I do not want to labour the point but it really is miserable being 'second on'. It is a demoralising slog, trailing around the wards from one sick patient to the next. The wards are entirely different from casualty; they are dark, there are fewer staff and almost invariably the equipment that you most need (ECG machine, ophthalmoscope, syringe) is either broken or missing. It is scandalous that in some wards the only way to physically see a patient at night is with a hand-held torch. There are times when the whole hospital seems to be 'going off' and one's bleep never stops. It can be a frightening and lonely time. In my experience of being 'second on', the first casualty was always my good humour.

Venflon

Gradually one starts to gain in self-confidence and perhaps even to enjoy the job. The everyday tasks become easier, (and you take a pride in arranging a CT scan within twenty-four hours) and you start to learn some practical procedures, for example lumbar punctures, pleural aspirates, chest drains, central lines, even venflons. Venflons, tsk, what an invention. I refuse to believe that they are inanimate. Instead they conform to a bizarre circadian rhythm such that they tease themselves out of a vein only in the hours of darkness. They are also tribal, as no venflon 'tissues' alone; if one goes, then they all go. Furthermore, for venflons Sod's less well-known second law applies, 'There is an inverse relationship between the necessity of the intravenous cannula and the size and number of appropriate veins.'

In-patient referral

No matter how long one practises medicine there is one thing that never seems to become easier--in-patient referral. Surgeons will simply deny that the patient has a surgical problem, and will mutter amongst themselves about 'bloody medics', whilst the physicians will agree to see anything. However, the medical referral is a cunning and dangerous beast. It is imperative to have all the information at your fingertips, as you will be continually interrupted for this or that serum level, or worse--the arterial blood gases. It is often introduced as a casual remark somewhere towards the end of the discussion, but always with the implication that you really ought to have taken them already. No matter how well you prepare, they always catch you, if not with the result or investigation, then with some dazzling observation that consultant's only ever seem to make about *other* people's patients.

It would be impossible to exaggerate the awfulness of those first few weeks as a house officer, but things do get better, much better in fact. It is definitely a year to remember, and as I adjust my rose-coloured spectacles and look back on it, it is a year I will remember with affection.

T Plunkett
***Senior* House Officer**

The windsurfing extravaganza

A London-wide experience

It all began in November, when our trusted captain of UMDS Windsurfing Club (Roger Lightfoot) got bored. Having perfected the art of organising the UMDS Windsurfing trips, he decided to allow the whole of London to join in the fun.

Windsurfing is a relatively new sport, and the University of London do not have a Windsurfing club. Roger was sure that the interest was out there, and decided to organise a competition that all the colleges in and around London could participate in.

After a good response from a 'flyer' letter, it was decided to get a sponsor from one of the big windsurfing companies. This would then mean that all the windsurfers would be able to sail the same equipment. The sponsor came in the form of BIC UK and Guy Shilvers. He offered to supply 40 boards and rigs for the occasion, and also there was the possibility that Barry Edgington (the recent world champion) would be there too!

A venue was required. After much pondering and driving round the coast of Essex, Clacton-on-Sea was decided upon. Clacton didn't just have hundreds of amusement arcades and fish and chip shops, but also a very large beach and promenade: ideal for the many spectators we were expecting.

Clacton County Council made life very easy for us to organise the event. After many letters life-guards were reserved, police informed, and most importantly Tower Caravan Park kindly organised a special deal so that everyone could stay very cheaply in caravans for the weekend.

The weekend of the event (May 15th and 16th) soon arrived, and in true UMDS Windsurfing Club tradition, we packed up the purser's van. There was however the slight problem that the boy's from 'Suicidal Penguins' were coming to play at the party on Saturday night and all the band equipment and disco had to come too. In convoy we made our way to Clacton.

Friday night, the forecast looked daunting. An ominous low pressure over Clacton, with windspeeds of 35 miles per hour, was predicted. This made the committee very anxious, as there was a huge possibility of death on the course!

Luckily the weather came good and we woke to a beautifully sunny day with Force 5 cross-shore winds. This was possibly the best windsurfing weather all year. We 'pitched' the registration caravan on the promenade, and swarms of hunky windsurfers began to flock to it. The first to arrive were Rusty Marshall (of recent Big Breakfast fame), and Simon Pearce and Guy Shilvers of the BIC team. They began to set up all the boards and rigs.

Meanwhile back at registration, Essex, Imperial Royal Vetinary College, Cambridge, Watford College, UMDS, St Mary's Hospital, UMIST, Hatfield Polytechnic and the Royal Free teams had arrived. All of these colleges managed to produce at least two teams of four competitors, so we had a potential 80 windsurfers. However due to the excellent wind, it meant that the less experienced sailors would not be able to compete.

Much organisation then followed, checking the windspeed, placing the course marker buoys in a simple figure of eight and putting the 50 eager windsurfers into heats.

The heats began and a very good standard was set by all the competitors. Unfortunately our team's biggest asset on the windsurfing front was too busy organising, but UMDS was credited with Richard Guiness, Mark Lewis and Nik Hennessey. Richard Guiness and Mark Lewis both managed to get into a semi-final. Throughout the day we managed to run two rounds of races. At 4pm the wind died and everyone retired to Tower Caravan Park exhausted but excited at the prospect of the social event.

The social event came and went in a blur, the Suicidal Penguins played a fantastic set later in the evening, which the 150 party-goers all enjoyed. Around 1am the social ended, and most departed to 'The Vets' caravan. What a party! No lights and just a mass of bodies bopping up and down in the darkness!

Sunday morning came with headaches, but even more wind and sunshine. Racing again started at 11am, although the field had thinned slightly due to competitors feeling worried about sea-sickness! Another two rounds of slalom were completed with UMDS hopes resting on Ronan Brown (on Saturday he had decided that the pub was a better option!). In his first round he managed 2nd place in the final, an excellent piece of sailing. The windsurfing however was dominated on both Saturday and Sunday by Richard Dudley from Essex University and Paul Shotbalt from Cambridge (this year coming to UMDS). 4.30pm racing ended, and there were frantic calculations from the resident computer (Tracey Williams) to produce the results.

The individual was won by Richard Dudley with our highest placed competitor Ronan Brown in 8th place. The team winners were Cambridge with UMDS only managing 6th position. Guy Shilvers donated a few prizes, said

a few words and then everyone departed, thoroughly exhausted, but all acknowledging what a great week-end it had been.

Although UMDS didn't do too well in the placings, the competition was a great success for us. We managed to bring together loads of students from around the country, all of whom had a great time out. However 12 colleges had pulled out the week prior to the competition.

UMDS also managed to show how a competition could be organised on a shoestring. Next year should be better, as there were a few teething problems to be sorted out. For example, how to get windsurfers on the beach for their heats at the right time (a source of argument over the weekend!). Also, hopefully BIC UK will put some more money into the competition, which will lead to larger prizes and more boards.

Finally we would like to thank:

- Rusty Marshall and Simon Pearce, for spending most of the weekend rigging up sails and helping with the competition. We also thank Rusty for pulling off some wicked forward loops!
- Tendring District Coundil and the local police, for letting us have the competition.
- The voluntary lifeguards, who made 15 rescues over the weekend.
- Dr Richard Palmer (from the Periodoitology department), for coming along and supporting us.
- Also to all the girls: Kate Robinson, Tracey MacIntyre, Rachel Healey, Lorraine Foley, Miranda Champion and Kate Blanche who ran around all day collecting results.

Tracey Williams & Roger Lightfoot

Communications and learning

An overview of the course

In October 1992, a new course appeared on the timetable for first year students at UMDS : "Communication and Learning" (C&L). The course was organised by Professor John Weinman (Department of Psychology) and Leslie Millard (Education Advisor) after major emphasis from the General Medical Council that a students learning should include both communiation skills and developing their learning skills. The two were linked together at UMDS, as both courses follow along common themes and their frameworks could easily be intermixed. So, now in its second year, what does the course entail?

The objectives of the course are to enable students to:

- Identify their existing skills as learners and communicators, and to be given the opportunity to build on them
- Be able to reflect on their own learning ability, with the facility of guidanceright from the start of their course
- Be able to recognize the importance of being able to communicate well with patients, staff, and other students
- Gain experience and understanding of the way that effective learning and communication are interdependant
- Have an opportunity to work with a patient in their first week onwards, in order to give importance and relevance to the work in other aspects of their learning; and to demonstrate the importance of aquiring good communicating skills
- Have the opportunity to learn a variety of learning and communicating skills at the start of their careers, to help them as they progress.

Due to initial timetable constraints, the first week of the course saw students starting on the Communication side of the course. This involved small group work and working in twos and threes.

As Professor Weinman explained, the objective here was to facilitate communications between the students in their tutor groups, thus providing a

chance for introducing each other and getting to know each other in preparation for all the time they would be spending together in the terms to come.

Another reason why C&L was timetabled so early was to provide students with an opportunity to meet bona fide patients. The reason for this, other than for practising communication, was to provide a motivating factor for the students, and as one student remarked, 'It reminds us we're studying medicine, not just a science'.

In the first year the course ran, there was also a Learning session during the first week. However, this has been pushed back to the fifth week this year due to the feedback received from the students indicating that it didn't seem right to give guidance on learning techniques, before the had experience of it.

Feedback is considered particularly important by Professor Weinman in giving an overview of how the students are finding the course. From the feedback received so far from this years first year students, Professor Weinman has already begun pencilling in changes in the course structure for next year.

He explained, 'The feedback is extremely useful in assessing the progress of the course. Overall, the feedback so far is very positive. The main lesson from all the student comments is that the introductions to the tasks were longwinded, and so that is something to be changed for next year. The most positive feedback concerned the meeting with the patients, although it was remarked that some of the patients seemed a little over-rehearsed in their roles, which impaired the realism of the meeting slightly'.

Professor Weinman's main oblective throughout, however, is that the course should be enjoyable and that is certainly the case.

The future target of the UMDS Medical Education Committee is that the course be fully integrated into the Medical course to give a full five year program with, ultimately, an assessment of communication skills.

It can be seen then, that the C&L course will (quite rightly most believe) become a major integral part of the medical course, leading to more communicative and, hopefully, more caring doctors.

With thanks to Professor Weinman.

Anthony Parsons

Project ORBIS

Flying the flag for ophthalmology

Having crossed the minor(?) hurdle of the pathology exams and being interested in planes and things of that ilk I decided to go down to the Biggin Hill International Air Show on a sunny June weekend. There was also going to be a rather interesting aeroplane coming down to Biggin, and I don't mean the Russian fighters that have been exhibiting around the world in recent times. I had my reporters hat on since I was going to pay a visit to the plane owned and operated by ORBIS International. This is a DC-8 aircraft that has been specially converted into a flying ophthalmology teaching hospital. From the front back, there is a tutorial room, an audio-visual centre, operating theatre and recovery area. Space is limited, so the cockpit doubles as the waiting room!

ORBIS International is a charity organisation which was set up in 1982 with the original intention of tackling blindness in developing countries across the world. Although operations are carried out on board, this is the smallest contribution that the ORBIS project makes. Considerably more important is the teaching and the skills-transfer to the local medical and nursing staff, the promotion of blindness prevention and also the public relations exercise in

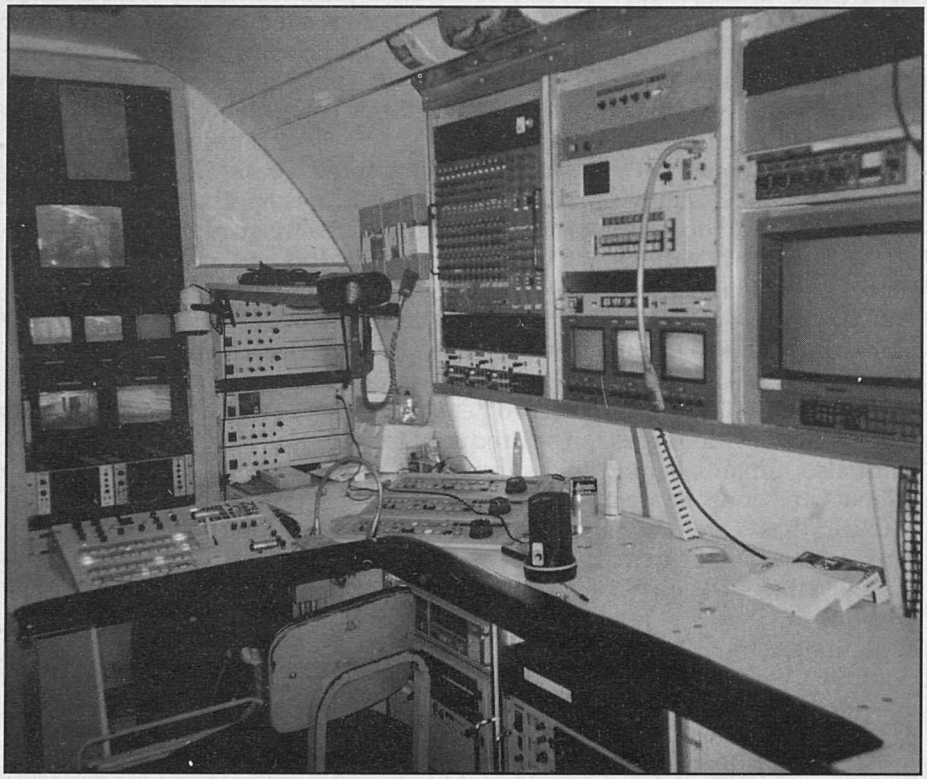
raising the profile of ophthalmology amongst governments and populations alike.

Over a decade has passed since ORBIS was launched, and in that time over 60 countries have been visited. Although the majority of destinations are in the developing world, ORBIS has visited industrialised countries, both to raise awareness for fund-raising purposes and in order to be able to video more advanced procedures for future distribution. All the destinations that it flies to are at the request of the respective departments of health and ophthalmology organisations. A considerable amount of preparation goes into each visit, commencing almost a year before the aircraft actually arrives. An advance party discusses with the local doctors their particular needs and requirements and a programme of topics is compiled. Nearer the time, another visit is made to screen and select the patients who will be operated upon taking note of those who would make good teaching cases and their ease of access to the plane. Once all these arrangements have been made, the plane is then ready to arrive. Usually this takes place amidst a flurry of media activity which goes towards helping the cause of ophthalmology.

The plane remains at each destination for three weeks. During that time, visiting surgeons lecture on and demonstrate various ophthalmological techniques with local doctors assisting. By the time ORBIS is ready to depart, some of the local staff will have had the opportunity to carry out some of the procedures demonstrated. The operating theatre on board the aircraft has a two-way audio-visual link with a small tutorial room actually on board the plane, and a link is usually also established with a classroom on the ground. This link is one of the most helpful elements since it expands the scope of the teaching allowing all the doctors to hear and see what is going. It also means that a series of video tapes can be produced for subsequent study. A follow-up team also remains behind and subsequent visits are made to check on the patients and consolidate on what has been achieved.

ORBIS has a field staff of 25 members, including ophthalmologists and nurses as well as support staff for the aircraft and audio-visual links. Two to three visiting surgeons from ophthalmic centres of excellence come for each week of the visit, freely volunteering their time. Other specialists including epidemiologists and community health physicians also donate their time, as do the pilots flying the ageing DC-8. The ORBIS field staff have one or two year contracts and so are paid. The field ophthalmologists are usually at SHO grade and get paid at similar rates. It is certainly a job that can be considered if one is choosing ophthalmology as a career and wants a change of scenery from Britain.

Mr Ffytch, a consultant at St Thomas's, was one of the surgeons who recently went out to ORBIS while it was in Lithuania just before it flew into Biggin Hill. I went to speak to Mr Ffytch about his experience as part of the ORBIS programme. He is already involved with improving ophthalmological facilities in Eastern Europe as readers of the Gazette may remember from the Operation Tallin article. Mr Ffytch felt quite strongly that one of the main ways of helping the doctors in Eastern Europe would be to concentrate on teaching the fundamentals of ophthalmology rather than performing cutting edge surgery which would be inappropriate to the facilities available in most centres in Lithuania. Consequently, one of his conditions for going was that



The interior of the ORBIS aircraft. Don't be fooled by the wide angle lens--there isn't as much room to work in as there looks

he would only lecture and not operate. The topics covered included diabetic eye disease, retinal vascular disease, macular degeneration and lasers and the standard he was aiming at was that of UK undergraduates or early post-graduates. To the 80-90, mainly female, doctors that he taught, this type of teaching was rather a novelty. They had been used to Russian based teaching. Now, questions were actively being encouraged. It was not just the medical staff that were taught. The nurses and technicians were also involved in training their counterparts.

Mr Ffytch commented that when ORBIS was concentrating on surgery, it used to be viewed with a degree of scepticism by the British ophthalmological community, including himself. However, over the years there has been a definite change of emphasis; so much so that some of the programmes that are carried out do not even involve the plane. Improvements to the advance preparations and follow-up visits, better briefings for the doctors and time spent on preventative ophthalmological measures have, he feels, made ORBIS much more useful to the countries which it has visited over the last five years. ORBIS has also now become involved in the leprosy projects with programmes in China. There is always a degree to which the most recent advances are covered. Often, local doctors want to hear about these recent developments even though they may not be directly relevant. After all, which self-respecting professionals would forego the opportunity to acquaint themselves with the developments in their field.

ORBIS International's 32 year old DC-8, the oldest aircraft of its type still flying, is overdue for replacement. In fact, donations from two businessmen from Hong Kong and America has enabled the purchase of a DC-10. This larger aircraft has not yet entered service since another 2 million is being raised so that it can be fitted out with all the facilities required. It is hoped that this new plane will be ready to enter service at the start of 1994.

ORBIS International is an independent organisation wholly subsisting on donations. No funding is received from any governments. They are certainly glad of donations, whether it be from equipment manufacturers such as Zeiss and Hewlett Packard who have given microscopes and a defibrillator, or from individuals, and whether the contributions are large (eg a plane) or small. Donations can be sent to: ORBIS, FREEPOST, PO Box 1685, London W8 7SP. If you want further information, there is also a short video about the work of ORBIS that will shortly be available in the Gordon Museum.

Fuad Hussain

Pre-clinical Pharmacology

Pharmacology--A Review With Questions And Explanations by Manuchair Ebadi PhD. Second Edition. Price £21.50. Publisher Little Brown and Co.

At first glance, the 500+ pages look a little forbidding, however once opened the story alters slightly...

Firstly, the text only occupies half a page, leaving plenty of room for supplimenting the text with lecture notes and annotating the (sparse) diagrams. There are a multitude of clear and concise tables, and the text itself is well broken up and easy to read.

The content is very good, providing both the basics (making it useful from the first preclinical year onwards) and the background, allowing wide reading and a good depth of understanding on each topic.

At the end of each chapter there is a selection of questions with an answer to each and an explanation for the answer. Overall there are 400 questions in the style of MCQs providing a self-test on every aspect of Pharmacology. Also at the end of each chapter there is an additional reading list of (usually) monographs on subjects pertaining to each chapter, to provide a guide on where to look for further background reading.

In summary: a very worthwhile buy and is certainly on par with other major pharmacology texts e.g. Rang & Dale.

Criticism: As it is written by an American, some of the names given in the book aren't the ones given in lectures, but usually if a drug is named, any other names it goes by are listed too.

Aids To Pharmacology by Steven Sacks and Roy Spector. Third Edition. Price £11.95. Publisher Churchill Livingstone.

This book has an unassuming cover, containing 232 well laid out pages encompasing 19 different aspects of pharmacology with a handy, short review of the fundamentals and terminology, together with an introduction. Unlike a great majority of books, the introduction is actually worth reading! It offers advice on the examinations to be taken and is written with the air of experienced examiners.

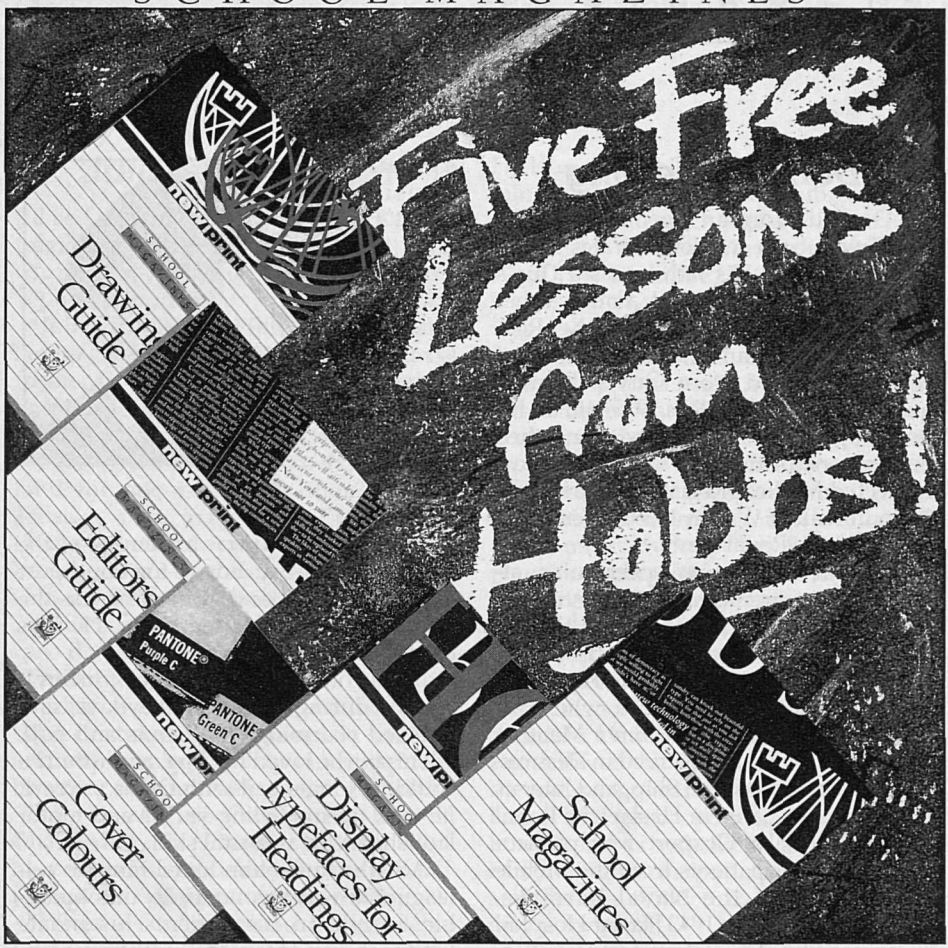
Before I go any further, I'll just mention the fact that both authors are at Guy's Hospital, and so any students would be advised to be well aware of what is said about exams...

The text is very easy to read, in the style of revision notes that most of us (should) make. The information is very clear, but it must be stressed that this is not a cheap pharmacology textbook, but as the title indicates, a guide to pharmacology.

This is in fact a very good revision book, with very clear diagrams of reactions and good concise text. It is at least as good as 'Pharmacology at a Glance' by Neal (in fact I personally prefer this book to Neal's, as the diagrams can be a bit misleading in Neal's) and is a worthwile buy for Freshers and Finalists, as well as anyone who would like a clear concise review of the subject.

Criticism: Well, try as I might, I can't find anything that irks me, or is unhelpful in this book. In fact, I only intended reading a few passages for this review, but I ended up reading up Histamine and now understand it fully!

Anthony Parsons



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Donald Leeming

Dr Donald Norman Leeming, MRCS, FRCP was born in North Wales into a medical family. His father was a Guy's trained GP/surgeon and among other Guy's connections were his brother Roy, his uncle Arnold and a cousin John, all of whom qualified from Guy's. Donald qualified MRCS LRCP in 1935, did all his house appointments at Guy's, and then became one of the best loved and most respected Medical Registrars there, until the outbreak of War in 1939, whereupon he joined the Royal Navy.

His war career was spectacular, although his extreme modesty restrained his own discussion of it. At the time of Dunkirk he accompanied a party of Marines to Boulogne, to treat and repatriate severely wounded casualties, where his skill and bravery earned him a Mention in Dispatches. He then served in Destroyers at sea, in a Hospital Ship, and later as a Medical Specialist in Haslar, the Royal Naval Hospital at Gosport, with particular concern for patients from the Mobile Chest units of the Naval Barracks, Portsmouth. In June 1943 Haslar Hospital became a clearing station for casualties from the Invasion. All the operating theatres were at full stretch and Donald took over anaesthetics. It was there that he met and married his wife Diana, a VAD at the time.

Finally he was drafted via a special convoy to the Royal Naval Hospital in Colombo, as medical specialist. There he taught collegues the care of tuberculosis and dysentery, diseases which were rife in the island.

On demobilisation in 1945 he returned to Guy's to complete his Senior Registrarship and gain the MRCP. He was then appointed Consultant Chest Physician to the Southport and District Hospital, the Ormskirk Hospital, and all the sanatoria between Preston, Ormskirk and Liverpool. He was a member of the Medical Advisory Board for Southport and Ormskirk, and Secretary for the Ormskirk Board for ten years. He was elected FRCP in 1971.

In his youth he played rugby for Guy's 1st XV during one of its heydays, and dabbled charmingly in tennis and golf. All his life he loved reading, and when he could no longer sail with Diana as crew, he took up modelling yachts and motor launches with a natural skill.

All who knew him loved him. To colleagues he was a wonderfully unforgettable friend. To his patients his innate kindness, goodness, and deeply perceptive understanding earned him the affectionate respect and admiration due to a truly great physician. Donald died aged 81 on September 10 1993. He is survived by Diana his widow, two sons, Timothy and Ian, and four grandchildren. He will be deeply missed by us all.

David Stafford-Clark
MD, FRCP, Hon FRCPsych, DPM

Julian Mountfield

Julian Gregory Mountfield, aged 30, died tragically in a road accident, whilst on a four-wheel drive expedition, on September 29th 1993.

Julian was educated at 'Barnard Castle' before entering Guy's Dental School as a fresher in October 1981. He qualified as Bachelor of Dental Surgery in 1985 and after two years working in hospital Oral Surgery posts ventured to Newfoundland for one year, with the Grenfeld Trust, to participate in the Community Flying Dental Service. Upon his return he became a well-established and respected General Dental Practitioner, while keeping his connection with Guy's as a part time demonstrator in the Department of Oral Surgery.

Julian was a competent and conscientious dentist with an interest in surgery and implantology. Julian never aspired, however, to publishing such tomes as 'Three Point Cusp Contact and How It Changed My Life!' Instead he channelled his enormous enthusiasm for life into the pursuit of outdoor adventure and travel.

Whilst at Guy's he pioneered a successful Dental Elective to (dare it be mentioned) Peru, and with the rich experiences he gained from this trip, including narrowly escaping being shot, he was able to fuel his enthusiasm for many more like it.'

Julian's greatest passion as a student at Guy's (with the exception of the Physiotherapy School) was skiing. He was the founder of Guy' Ski Club in 1984, and represented the University of London in the English and Welsh University Ski Championships in Switzerland in 1986. He later trained in avalanche and mountain rescue with the Ski Club of Great Britain in the French Alpes and had also organised an Extreme Expedition for April 1994 to ski the Haute Route. Julian was as much at home on the water as he was in the Alpes. Having rowed for Guy's and Putney Rowing Clubs, he progressed from slave to master and took up sailing. He achieved the RYA Coastal Skipper qualification and was a known Cowes' Week 'Dock-rat'. He was a competent dingy sailor, waterskier and scuba-diver.

As if this wasn't enough he would sneak off at midnight on Saturdays to play ice-hockey (an unsociable habit he acquired whilst in Newfoundland) where he played centre for Bracknell Vets. Julian never failed to entertain. Every event he attended was graced with some memorable and usually humorous anecdote. He was loved and will be much remembered for his bottomless teapot, the lost ensign, banana skins in the linen basket and gazpacho soup, not to mention his snares and edible candles. Julian had a unique charm, enviable humility and that rare ability to treat everybody he met as an equal.

Julian's life would not have been complete without Juliet, his 'wifelet' who loved, cared for and encouraged Julian for seven wonderful years. Our heart goes out to her and to his parents Brian and Dorothy and his sister Emma.

Julian was a unique and adorable friend, and as his friends we are extremely privileged to have been part of his extraordinary life. He will be so deeply missed.

His friends

Peter Lommerse

Dr Peter Lommerse died suddenly at his retirement home in East Sooke, British Columbia on August 18th, 1993. After qualification from Guy's in 1949 he went to East Africa where he felt that he could make a more significant impact as a doctor and remained until 1957. He returned to England and obtained his DPH and DIH after which he moved to Canada and became Director of the Northern Health Services in the Pas, Manitoba. In 1963 he entered private practice in Dunrea and Killarney, Manitoba, until his retirement in 1992. A belief that rural general practitioners were not well represented in medical politics in Manitoba led him to run as district representative culminating in the Presidency of the Manitoba Medical Association in 1974. Following this he became actively involved with the College of Physicians and Surgeons of Manitoba, becoming President in 1992, one of only four people to have held presidencies in both associations. Both these positions involved considerable reorganisation of his professional and family life. In order to avoid being an absentee rubber stamp President of the MMA Peter and family moved to Winnipeg where he took part time work having placed a locum in his own practice. College and Committee work involved frequent journeys to Winnipeg from his home in Killarney, 140 miles distance over very difficult winter roads and flying in light aircraft in doubtful weather. Peter was unflagging in all areas of his life despite a variety of illnesses, suffering from MS in 1965, a major undiagnosed illness in 1979, coronary arterial bypass in 1982 and subsequently becoming a severe diabetic. He was a devoted husband and father, friend, community activist and a concerned family practitioner, lovingly remembered by his patients. He is survived by his wife Ira, two sons and two daughters.

Dr J A Jemson
Port Alberni

Strike!

A spectre is haunting London's hospital nurses--the spectre of funds being withdrawn which support NHS care for patients. All the powers of managers, health authorities and government ministers aim to exorcise those who seek to maintain the service at its present level. Nurses at one London hospital were prompted to take strike action recently at the prospect of closure of their hospital. We are yet to hear the effect of decisions to be made which concern our own merged hospitals, later this autumn. But it has become clear that some considerable sums of money need to be saved to avoid overspend, and man (or woman) power will need to be reduced.

But will there be strike action on behalf of patient care? I imagine few readers would support this, however much and support and sympathy there may be with reasons for such a protest, if it arose. Nurses have often been quoted that they would refuse to strike because this would endanger patients' lives: this has not stopped 'rationalisation' of services, which has very much the same effect. Patients will be inconvenienced, either if there is withdrawal of a particular service, or it is transferred to another centre, entailing extra time and travel for them to obtain care and treatment.

Nurses are concerned, not only about the possible lack of work to provide them with a livelihood, but with the conditions under which they are expected to give that care. If strike action draws government and managers' attention to their concerns, and if it is seen as the only method, is it justified? Nurses who have joined this recent strike, but sought to provide emergency cover, found themselves facing possible disciplinary action by management. Nevertheless the nurses found that management itself was in a difficult position, and not one of, its own making. These nurses were directing their anger at government and believe the present situation arose out of the internal market and the politicians who introduced it to the NHS.

At the time of writing there is anticipation of cuts in public spending to be announced in an autumn budget, and a very tight rein will therefore be placed on health authorities' expenditure - a pecuniary state already suffering previous curtailments. The immediate response to confrontation through strike action under this stringent financial policy is not favourable. Nurses would damage both their care and their image. Inevitably, one cannot strike, and yet say at the same time that this will not cause injury to patients. If this is true, it plays straight into opposition hands - that there must be too many staff now! The image the public have of nurses is still good, better probably than some other professions.

If nurses wish to retain this image, they must look to the community which needs their care, for here at grass-roots level are those who need supportive amenities, provided as an alternative to the paternalistic patronage which they have seen provided by orthodox bureaucracy in the past. Nurses must ensure that this background provides them with an authentic, participatory campaign of commitment in contrast to the provocational arrogance and divisiveness of Bourbons who currently preside. There is room for dialogue in the outreach zones, beyond the 'elitism of state patronage, despite the patronising management's assertion that such an approach may be purely 'emotional'.

One could go on - such is the 'in' and 'out' of language of proposals and counter proposals on both sides of the argument. Whether a strike may ensue, or whether nurses accept what they are told, and what they must do, is for them to decide. On past performance, it is difficult to adopt an optimistic rather than a gloomy view. Certainly morale is low, and needs a boost. It is unlikely that either strike action or supine agreement to a conceived poorer service will offer much uplift. A middle road must be found. A militant response may be needed at the end of the day if nursing as we know it is to survive. But I am not convinced that strike action will invite that focus.

Denis Cobell

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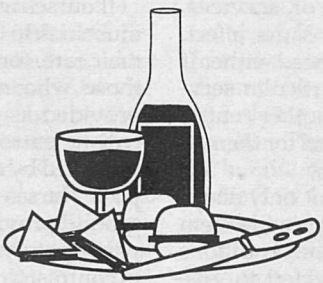

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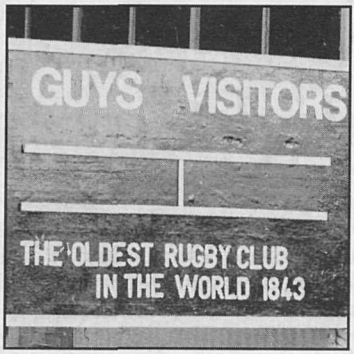
GHRFC 150 years anniversary highlights

Photos from Guy's Hospital Rugby Football Club

Below are a few highlights from the 150th Anniversary Festival Day. A full review of the day, with reports on the matches will follow in a forthcoming issue of the *Gazette*.

Left: Ed Bario with the University Hospitals cup
Below: The triumphant GHRFC team



Top: 'Just to prove it...'
Right: Mickey Skinner takes time away
Below: The UMDS Ladies' team

Above: Public School Wanderers and Medical Barbarians in action
Below: GHRFC succesfully mauling

GHRFC flag

UMDS 1st VII Netball Team--Year Report

Played 20. Won 18. Lost 2. Points scored for 529. Points scored against 261.

The year began with a riotous start to the season with the Fresher's Trials. New recruits were in abundance. Two teams were submitted to the University of London (UL) League in the First and Third Division.

Training took place down at HOP every Thursday night. Many thanks to Mel for taking the training sessions and knocking us into shape.

There was a slow start as we lost the first two matches, but we soon settled into our positions. They were the only matches we lost! The 1st VII went from strength to strength and by the end of the season were placed top of the First Division of the UL League.

Then came the UL Cup which was run alongside the league. We ended up in the final playing playing Royal Holloway and Bedford New College on the 20th Match in a hard-fought game. We scored a sucessful 41 goals against their 31; ending up as the triumphant winners of the UL Cup 1993.

By the end of the season, the pressure was off and so were we--to Jersey for a long weekend. This was enjoyed by all! Thus ended the third sucessful season of UMDS Netball Club, after beginning in 1990. Thanks to everyone who played this year and good luck to Charlotte, the new captain.

As always, we welcome anyone of any standard and we can be contacted through our pigeon-hole in Boland House.

K Scalan and N McDonald

The Jersey Tour Squad

Itchenor and Seaview--June 1993

The Guy's and St Thomas's Sailing Club had a busy season this year, being well supported in its trips to Burnham-on-Crouch, but the highlights of the season were the two outings organised by our commodore, Professor Sonksen, to Seaview on the Isle of Wight and to Itchenor.

Professor Sonksen managed to convince six Sonata owners to let a group of students use their boats and, having allocated the crew and the boats so that I stood the best chance of winning, we set off for our beds for the evening.

A few of the problems of living on a yacht began to dawn on the novices such as, 'Where do I plug in my hairdryer?' and 'Do I really have to use the bucket?'.

They soon settled in for a good weekends sailing ahead.

After a huge breakfast from the sailing club we were off to the Solent for some serious racing. Prof soon realised that he might be up against it when he shouted, 'Grab the sheet!' and Tim Wells grabbed on to the genoa and would have pulled it off the mast if he could--Well, it was big and white and did looked the most like the one on his bed. He was told to sit on the other side from the sails for the rest of the day.

The racing was close, so close in fact that I nearly joined another boat with mine. At the end of the day only one and a half points separated four crews.

The next morning found the captain up early to replace the Prof's not-so secret supply of wine, that he had mistakenly left on board overnight. It also found a lot of people looking a bit rougher than the day they arrived. However, the day was not for racing, as it was far too windy, but the consolation was that we had been sponsored some 'beverage'. An alternative plan perhaps? As there was no racing it was decided that the placings would be settled with a game of charades . The final placings, 1st Bill Francis, 2nd Charlie Sherwin, 3rd Marc Moncrieff.

Seaview--Consultants v students

This annual event is one of the longest days in the sailing calender for G&TSC The event is the consultants racing against the students. Briefing was very plain and simple--crashing the boats makes a big hole and is very expensive. Again I made sure I had a decent boat and crew, but only after the consultants had pulled rank and got the pick of the boats. The morning's racing saw the consultants consistently having three boats in the top four and it was looking grim for the students with only Phil Ridsell-Smith putting up a good show. This was the point where Bill Francis decided to slow the consultants down a bit. He ignored the morning's briefing, cranked the boat up to ramming speed, put his cutlass between his teeth and prepared to board the enemy. A big hole later and three glowering faces were staring at Bill all swearing that he will never work at Guy's, if he ever gets to qualify in the first place.

Following that we decided to adjourn for lunch and to swap boats, so that students might have a chance. Of course, the afternoon's racing proved that the boats weren't to blame--the students weren't good enough. We were soundly beaten by a strong consultant side.

Dinner followed and our chance to get a round out of the consultants. All that was left was the presentation of the Commodore's Trophy to the grizzly ol' sea dogs (again) and the piece of boat that was knocked out to Bill Francis. This is now the 'Halluf' trophy (the name of the boat) and is to be awarded to the worst sailor of the day.

Thank-you to Itchenor and Seaview sailing clubs for making us very welcome and Prof Sonksen for organising these events. Also a special 'Thank you' to Mrs Sonksen for doing the tough job of being on the committee boat and officer of the day. I hope more will become involved with the sailing club next year. We welcome people of any ability. In the meantime, I'm off for some warmer sailing in the West Indies for the winter.

Marc Moncrieff

Rugby 1st XV

First match of the season

Guy's RFC 1st XV v London Irish II 'Wild Geese'. 4 September 1993. Score 42-10.

On a hot, late afternoon (despite some logistical transport problems) Guys arrived at Sunbury to play London Irish Wild Geese.

Whilst maintaining a solid defence, strong Irish pressure allowed a whip through to the Guy's tryline, and due to the unfortunate intrusion, a penalty try was awarded to the Irish.

Guy's immediately replied with a penalty goal, following several difficult opportunities for further points from penalties, due to Irish indecision. Guy McClellon was set free on the left wing, but a head tackle by a 16 stone flanker left him out cold on the touchline. However he was soon revived, thanks to the tender loving care of the attractive Irish physio!

The Irish, match-fit after their successful tour to Canada, scored three more tries and a drop goal before half-time. The hospital needed all eight members of its pack to hold the large Irish front five from a rolling maul, allowing the Irish flankers to roam free in the outfield creating overlaps. Pete Davis left the field at half-time due to a knee injury, to be replaced by Matt Giles.

In the second half Guy's began to find their handling skills of last season, and were unlucky not to score on at least two occasions. London Irish only scored twice more. Guy's scored the final point. Breeze, overtaking Simon Geihgun on the next door pitch, intercepted a pass and scored from the Irish IO' line under the post.

Team: George Tsolikides, David Evans, Simon Riesal, James Burt, Billy Challawulse, Ed Barnes (Capt), Matt Giles, Pete Davis, Greg Ryan, Wayne Llewellyn, John Murphy, Steve Lewis, Jennery Worth, Max Henderson, Matt Rose, Guy McClellon, Richard Breeze, James Burt.

Richard Dales

Match report

Guy's Hospital Ist XV v Old Whitgifrians. 11 September 1993. Won 28-10.

Conditions were beautiful, but too warm at Cobham for this game and once more the Guy's team let an inferior side look good. For the first twenty minutes the hospital had to make do with scrappy ball, and then when we began to take possession of the ball--dominance was not forthcoming. Finishing was also less than decisive. Too many hands, too many missed overlaps, too many breakdowns in mid-field. Yes, well--we won, and the trys were good with Docker picking up two opportunities on either side of the interval and Neil Davis breaking through a couple of tackles for a determined try.

It was nice to win, but we could have played so much better. In reflecting on the game, that is glaringly obvious.

Match report

Guy's Hospital Ist XV v Old Cranleighans. 18 September 1993. Won 18-9.

It was time to redeem ourselves and our pre-match warm up seemed to show

a determination to win that had led been absent from last weeks start. However, Old C's did to us what we did to London Irish. 6-3 was the half time score in a poor team performance.

At the start of the second half however, a disaster struck for Guy's and more importantly Jeremy Worth when, during a tackle, he dislocated his tibio-femoral joint sustaining extensive ligamentous damage. I would like to take this chance to wish him all the luck in the world for his forthcoming operation. His powerful and frightening tackling will be missed by us, and cheered by the opposition of all the sides we will face.

It was 10 minutes before we could recommence the game and Guy's seemed fired up to win for Wocca's sake. The pack began to win ball, and the backs began to use it. Decisive and slick running opened up the defence, and allowed replacement centre and coach, Nigel Baker, to score two tries.

The last 15 minutes had Guy's being penalised repetively for basic mistakes, as Old C's tried desperately to score. An alleged high tackle gave them their penalty try, leaving the final score 18-9 Guy's.

Patrick Gush

Match report

Guy's Hospital 1st XV v Cambridge 60 Club. 25 September 1993. Won 33-19.

The hospital started off at a cracking pace and surprised Cambridge with the speed of their running and almost got over straight from the kick-off. However the ensuing ruck was won and the ball passed along the line for the wing to be bundled into touch in the corner. Following the line out the back row were driven over for the opening try. Signs of impending trouble however followed shortly and the Cambridge University centre put over a penalty from within his own half to make the score 6-5 to Cambridge. Guy's drove to the far end of the pitch and the penalty in the middle of the pitch was converted by Neil Davies to make the score 8-6. A missed tackle led the Cambridge No 8 through the centre for an converted try and one more penalty was awarded before half-time. The Guy's forwards were playing well in the loose and were winning a lot of ball. In contrast little ball was won from the line-out until the end of the half. Half-time score 16-8 to Cambridge.

Good close control of the ball in the middle of the pitch with rolling mauls by the forwards applied pressure to the Cambridge side and after several sets of hands had passed the ball, Challacombe went over for a converted try near the posts. Score 15-16. Guy's began to get a bit more possession in the second half. Rose was then injured in a tackle on their No 8 and had to go off with concussion. Another missed tackle saw Cambridge break almost to the Guy's line but a superb tackle by Breeze prevented a score. An impressive shove by the Guy's pack disrupted the Cambridge ball and allowed Docker time to stop the No 8 picking up the ball and probably scoring. A further penalty to Cambridge was converted and the total of five missed penalties by Guy's during the match could have been the deciding factor. After further impressive runs by the Guy's forwards, Cambridge killed the ball and the penalty in front of the posts was converted to give a score of 21-19. Guy's again showed their skill in loose play and quick interpassing through approxi-

mately six or seven pairs of hands led to a try by Billy Challacombe. The conversion hit the post, 26-18. Another thrilling exchange of passes of forwards and backs put Steve Lewis over on the right side--converted himself, leaving the score 33-19. Overall this was a very good team performance showing great commitment all round and a highly satisfactory result. Team: K Ivil, R Llewellyn, G Tsolakides, E Barrio, B Challacombe, W Llewellyn, G Ryan, P Cunnington, N Davies, S Lewis, R Breeze, M Rose, N Baker, A Jones, R Docker.

SJC

Rugby 2nd XV

Match report

Guy's 2nd XV v Old Whitgiftians 2nd XV. 11 September 1993. Won 58-10

With the HOP boiler not yet firing on all cylinders, the 2nd XV travelled to Cobham for their first game under their new leader John 'Refresher' Murphy.

Mike Seare was spotted pulling down, as is customary, the first scrum of the game. He chastised the referee, and the ritual dislike lasted for the duration. After an uneasy start, Pat Gush steadied the nerves with an early penalty, and the festival rugby began.

The magnificent Andy Skyrme scored the first try, after a typical Guy's 'length-of-the-pitch' flowing move that went through all the pack's hands at least once. Our very own Welsh speeder, Mark Howells, outpaced the old Whitgiftian backs to score the second, before Ally O'Brien, on his first ever game for Guy's having finally defected from Old Alleynians, opened his account.

Our backs were simply in a different clay from theirs and every time the forwards came up with clean ball we were soon twenty or thirty yards up the pitch.

The centre pairing of Max Henderson and Pete Goodyear cut Whitgiftians to sheds with Max scoring under the posts. Mark Lewis scored two fine tries from fullback, Ally added another, and Pat Gush scored in the corner to complete the rout. Not to mention five successful conversions from Pat Gush's trusty boot

Overall, this was a very satisfactory start to the season and good preparation for the harder games to come. John Murphy was suitably rewarded for his victorious start as skipper, and the boys moved to the Hole in the Wall and the Market Porter before universal oblivion...Team: Chris Howell, replaced by Warz, John Spencer, Mike Seare, Andy Bates, Tank, Paul Scanlon, replaced by Ed Larns, Matt Giles, Andy Skyrme, John Murphy (Capt), Pat Gush, Ally O'Brien, Max Henderson, Peter Goodyear, Mark Howell, Mark Lewis.

Andrew Bates

Match report

Guy's 2nd XV v O' Alleynian's 2nd XV. 2 October 1993. Won 30-8.

The clouds were black, the sky was angry, the faces full of pain. Despite the earlier rainy weather the sun shone brightly on Guy's RFC as all three sides braved the elements and the strengths of O' Alleynians and came out victorious at all levels. The 2nd XV took the pitch in buoyant mood (many of the boys fresh faced from their 'trip around the world' the previous night). The flowing attacks in the first five minutes, involving backs

and forwards, took us deep into Alleynian's 22' line. This took their strong fit side completely by surprise (and baffled us). This penetration was rewarded by two early penalties, both comfortably converted by Pat Gush. This provided a platform for the following performance; an outrageous monologue from Mark Howells catching their clearance kick after intense pressure from Guy's. Taking it on halfway, he ran towards Danny for advice, came back to the other touch line around the back of Alleynian's defence then straightened up. His pace beat the last couple of flimsy tackles and he went under the posts. Some fine interplay between forwards and backs took us again to their try line. From a 5 metre scrum Baldrick, with supreme confidence, burst through would-be tackles for our second try. Both were converted. Alleynian's came back towards the end of the first half as we sat back and conceded a sloppy penalty. Half-time saw the old guard of Davis, Scanners, Stron, Sear etc all chipping in with wheezy comments which primed us for the home straight. Andy Skyrme was instrumental in destroying his own oxygen reserves as he ran, riot-breaking, from scrums and lines. His attacks took us to the brink as, on occasion, a fluid and well-supported team effort had both our props snatching at the ball to score! A 5 yard scrum followed. (Yard?) A quick ball from the pack sent Baldrick into a crash enabling an easy pop to Gushy who burst through for our third try.

The icing on the cake came from superb support. Deep in our half and against the run of play, we opted to run. A secret double probation move between Davis and Stron in a two man line, came off like sticky Vicky's crackers on Prom Night. A well-timed Scissors between Gushy and Ronan parted their defence as the latter sped up the field. Linking with the other backs, Morgan gave the final pass to Mark Howells who squeezed into the corner for his second, and Guy's fourth try. A well-deserved score line in a keen and clearly fought contest. A true team effort enjoyed by players and spectators alike. A victory over a team two leagues above us was celebrated with Gin for John, and Guinness for the Guy's. Team: Ken, Sear, Stron, Bates, Pat Davis, Stewart, Livingstone, Scanners, Skyrme, John Murphy (Capt) Baldrick, Mark Howells, Gushy, Ronan, Danny, Jon Morgan.

Patrick Gush

Deaths

MAY, David George MB BS DRCOG, died suddenly at home on 11 September 1993. A General Practitioner in Surbiton, Chessington and Leatherhead for more than 40 years.

WANDLESS, Denis James, died at Shipton under Wychwood on 31 July 1993. Loving husband of Jean.

Apology

The mis-spelling of **WILLCOCKS** in the September *Gazette* obituaries and contents pages. We apologise to family, friends and collegues for this unfortunate error.

Wedding

On the 28th August two UMDS medical students, Philip Bejon and Sarah Atkinson, were married in Upminster.

Announcements

The Hallet Prize at the Royal College of Surgeons of England for the top person in the Primary Fellowship Examination in Surgery was recently awarded to Dr Cornelia Carr.

Dr H Winsley-Stolz has been awarded the MRCGP.

For sale

Bound copies of *Guy's Gazette*, 1887-1933 (1919, 1930, 1932 missing) available. Offers invited. Telephone Brant, 0272 823529.

Changes of address

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Dr C A Higgins
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South Wales Guy's Hospital Society

The 43rd Annual Dinner will be held at the Park Hotel, Cardiff at 7.30pm on the 15th January 1994. This is the evening of the Wales v Scotland match at the Cardiff Arms Park.

All trained at Guy's or UMDS, both ladies and gentlemen, medical, dental or nursing staff etc. are welcome. Guests may be invited. Price £20.00 per head (Excluding wines).

Please notify the secretary not later than the 5th January 1994 if you wish to attend:

Graham Davies
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Radyr
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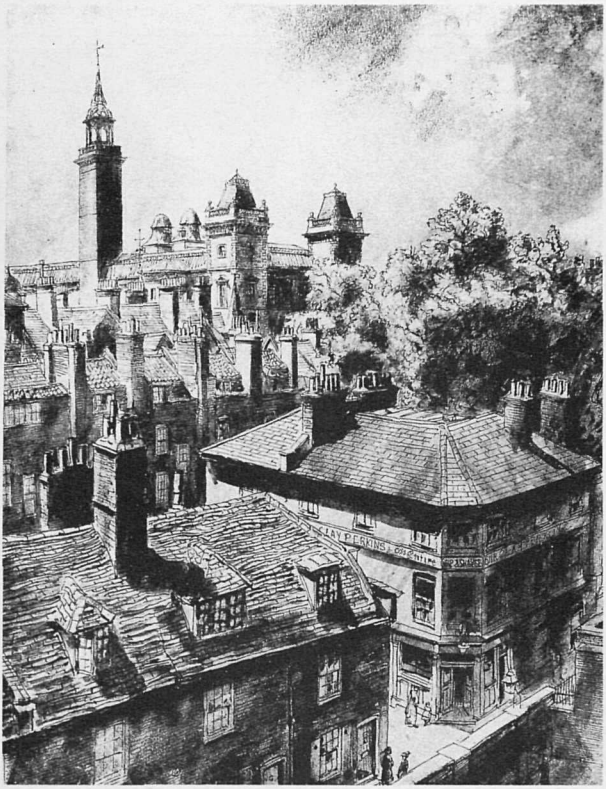
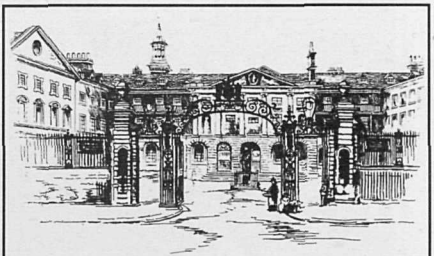


Christmas Greetings

Christmas

Greetings



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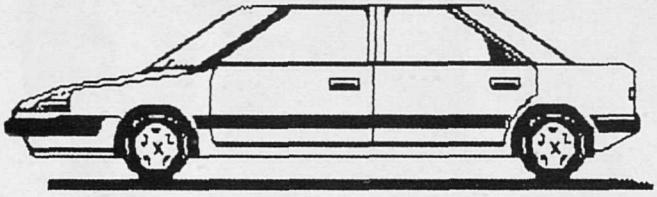

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CONTENTS

UMDS Guy's
15 FEB 1994
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2 **Passim**
3 **Letters**—'Nuffield' and Guy's
7 **News**—What is a bed?
8 **Feature**—Articles and experiences
13 **Feature**—Graphology . . . analyses and their accuracy
18 **Feature**—Life in the OTC
22 **Feature**—The Diwali show
26 **Feature**—Frank B West . . . 49 years at Guy's
28 **Reviews**—Pathology, resusitation
30 **Obituaries**—Joan Mary Smith
31 **Nursing Notes**—All change
33 **Sport**—Hockey, rugby, UMDS boat
43 **Classified and announcements**—New doctors

Guy's Gazette

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Passim

The themes of change and adaptation will no doubt dominate 1994, as they did through 1993, for Guy's and St Thomas's hospitals. The Trust, at the time of writing, is awaiting the Secretary of State for Health's response to its submission of proposed changes (see Gazette News). A response is expected before the end of January and hopefully then speculation and uncertainty can be replaced by a definite structure for change.

1994 will also be a challenging year for the Gazette. It has been suggested, that with the formation of a single Trust for Guy's and St Thomas's hospitals, the Gazettes of both hospitals should merge. Any decision taken will, naturally, be guided by changes within the structure of the Trust and its two hospitals but Guy's Gazette would most wholeheartedly welcome the views of its readers on the matter.

One change in the medical school certainly worthy of comment (aside from the rather surreal shade of pale blue paint chosen for the foyer) is the UMDS file-o-fax. This article, given to new clinical dental and medical students, contains course objectives, a summary of what is expected of students whilst on medical and surgical firms and what subjects are expected to be covered during quartiles. There are also drug sheets included, on which the student can record the use and adverse effects of drugs commonly encountered—a very useful aid to learning clinical pharmacology. As well as curriculum details and requirements the file-o-fax also gives orientation information about the medical school, clinical adviser system, and both hospital campuses. No doubt this will reduce the feeling of uncertainty encountered at the beginning of each new firm or quartile. They appear to be a definite 'plus'.

It is a shame that this passim, like 1993, will end on a rather sour note in terms of extra-curricular events. The Christmas show 1993, held as always in the bar of St Thomas's, was certainly no source of pride for those at UMDS. Though heckling is a traditional part of the show, especially on the last night, the degree of noise and abuse was such that the cast could not be heard and after valiantly battling through the first half, refused to continue. It is to be hoped that such audience behaviour is not repeated as such occurrences do little to promote pride, or even interest, in extra-curricular life at UMDS.

Stephen Duckworth's fortitude and determination

Dear Sir,
It is a long time since I have been in touch with many of you so I am simply taking this opportunity to contact anyone who once knew me and pass on my thanks to anyone who helped me as a student at Guy's Hospital.

For those of you that do not know me, I broke my neck when I was a first year clinical medical student in a rugby accident. After this I went back to medical school and qualified as a doctor in 1986. I was paralysed from the neck down other than some slight movement in my right hand.

Having qualified as a doctor I moved down to Southampton where I did an MSc degree in Rehabilitation Studies under the supervision of Professor D L McLellan (Europe Professor of Rehabilitation Medicine). After my MSc I started a PhD on a full time basis but soon changed to a part-time student as I was finding other interests outside the world of academia.

In 1988 I went to Australia on a Winston Churchill Travelling Fellowship to investigate the roll of disabled people in providing community based services. On returning from Australia I set up a business--Disability Matters Ltd. This commercial organisation now employs six people and has eight associates, all of whom are themselves disabled people. The company provides Disability Awareness Training mainly for employers to encourage them to recruit more disabled people into the work place. We also provide training for medical students at Southampton University, Physiotherapists, OTs, and Social Service Departments in local authorities. The company has expanded rapidly over the last five years.

More recently, I have set up a charity called the Bridge Trust. This Charity is seeking to help employers find it more easy to recruit disabled people by providing a recruitment service to employers in the Hampshire area.

I have also been appointed a trustee of another charity and am a member of the Prince of Wales Advisory Group on Disability, and a director of the Princes Youth Business Trust.

I have now completed my PhD. This is with the examiners and I am awaiting the viva. My work also takes me abroad and I have recently given a presentation to the All Party Disablement Group of MEP's in Stratzburg, and was invited last year to act as a consultant to the Government of Bermuda.

On the family side, many of you will remember my partner Rose. Rose qualified as a Physiotherapist and worked in Southampton for several years. We got married in 1988 and now have two children--James, 22 months, and Edward, 8 weeks.

Over the last two years Rose has been setting up her own business in Salisbury. This is a Health and Fitness club run by three women. As well as a large fitness gym it also has a dance studio and there is a sports physiotherapist practice as well. She is extremely busy both with the business and the children but is thoroughly enjoying life.

Once again many thanks to those of you who gave me some initial help, either

practically or by raising some money to help springboard me back to life after what was a very difficult time. I will be attending the 150th Anniversary of the Rugby Club and hope to see some of you there in April. If any of you feel like getting in touch with me then please do not hesitate in dropping me a line at my new address: Berkeley house, West Tytherley, Salisbury, Wilts SP5 1NF.

The best advice that I ever received by a fellow rugby player after my accident was 'don't let the b..stards grind you down'. Although becoming a disabled person could not be described as the best thing that has ever happened to me, it has certainly given me a great deal of drive and determination and a desire to achieve far more than I had ever expected to do as a medical student. It has given me an opportunity which I hope to grasp with both hands.

Many thanks to you all.

Yours faithfully,

Dr STEPHEN DUCKWORTH
Disability Matters Ltd
Berkeley House
West Tytherley
Wilts SP5 1NF

'Stephen Duckworth's fortitude and determination remain an inspiration. Despite a devastating rugby injury he qualified, married and has a busy professional and social life. He maintains a keen interest in the medical school and especially Guys RFC'.

SHEPARDS HOUSE

'Nuffield' and Guy's

Dear Sir,

All your readers will have heard of 'Nuffield', ie William Morris, but few will remember the part played by Guy's in steering much of the 'car money' towards medicine--and this was greatly helped by J J Conybeare.

I was 'Cony's house physician at Guy's about 1934 and hence occasionally met Lord Nuffield. He and 'Cony' were great friends and used to play golf together at Huntercombe. An early gain by Guy's was the building of Nuffield House, then the last word in medical sophistication. My two eldest sons were born there in the late thirties.

The above would not merit this letter, but I have now learnt a lot more. 'Nuffield, a biography' by Martin Adeney (Hale 1993. Price £18.99) has recently been published and it is a fascinating book, which filled in many of the details that I might have known in 1934. Thus when 'Cony' was an undergraduate at Oxford he was wealthy enough to have had a car, and it was garaged by none other than William Morris, and the friendship started then. (Morris also serviced Osler's car).

Nuffield prospered tremendously with the Morris cars but he rarely gave if pressed, and delighted in surprise donations. 'Cony' once just mentioned to him about nurses whose savings had been embezzled by a con man and then Morris wrote them a cheque. Approached in this way by 'Cony' and Morris's banker, Sir William Goodenough, the medical benefactions were very successful--by contrast with his bitter battles with Oxford University.

Many biographies relating to wealthy men concentrate on details of their benevolences but this book is 'warts and all' and therefore much more interesting. Adeney writes, 'There was something decidedly unpleasant about the way Morris used his money as a blunderbuss. His benefactions worked best when they were planned and directed by shrewd and sensitive allies....it was due to them that the Nuffield Foundation won and maintained a reputation for supporting thinking solutions to modern problems.'

Had Nuffield known how successful the Foundation was to become this legacy would have pleased him, and it might not have been necessary to report (Adeney) that for all his huge achievements he died a disappointed man. The last sentence of the book is sad, 'For all his claim to be at the forefront of the modern world he could not understand it.'

Yours faithfully

SIR CYRIL A CLARKE
43 Caldy Road
West Kirby
Merseyside
L48 2HF

The Work of Edward Proctor

Dear Sir,

All will have read with interest David Cooper's articles on Guy's men, in particular those associated with organ transplantation. As someone who was very much involved with cardiac preservation which Brock fostered in the early and heady days of cardiac transplantation, I would like to mention the incredible work that Dr Edward Proctor did for Lord Brock both in the Thoracic Surgical Research Unit at Guy's in the 60's and then subsequently at the Royal College of Surgeons in their Department of Surgical Sciences.

Ted Proctor was a man with an inexhaustible capacity for work and an uncanny ability to remain and appear as a backroom boy. Aware of Ted's qualities and with all the hullaballo about removing the heart for transplantation, Lord Brock gave Ted the work of cardiac preservation; the removal of the donor heart had to be distanced in time from the subsequent transplantation, for the scurrilous press and cartoons at the time had put the fear of god into the public about such transplants. As president of the Royal college of Surgeons and a pioneer in cardiac surgery Lord Brock was at pains to encourage this work and at the same time ease the public conscience. He could not have chosen a better person than Ted Proctor to carry out this research that soon led to a method of successful orthotopic transplantation. This work was written up in the British Medical Journal in 1968.

The fact that such an interval of time is no longer a necessity nor indeed essential for ex-vivo organ preservation does not diminish the success of Ted Proctor's work which to my knowledge has yet to be exceeded let alone even repeated to this day. Furthermore, this experience was Ted Proctor's subsequent base line for all the perfusing experiments of other isolated organs for transplantation particularly the kidney, when he moved to the Department of Surgical Sciences at the College.

Ted's various contributions to surgical research have been extensive over the years, yet such is his nature that he is

more likely to be the driving, thinking as well as doing force behind all his various research projects than the front man. Perhaps one day Dr Edward Proctor's full contribution to bench surgical research will be highlighted.

Yours faithfully,

ROGER PARKER
Clinical Anatomist.
Division of Anatomy and Cell Biology
UMDS

Guy's reunion dinner 1939-47

Dear Sir,

In 1988 Dr John Fry CBE had the idea that it would be enjoyable to hold a reunion of people who had been his fellow students and qualified in 1944 with one of our old teachers as guest of honour. A successful evening, organised by the late Derrick Morton at the Royal Society of Medicine was attended by some 20 people. The number included a few from other years who had heard of the occasion. Our first guest was the late Dr C S Darke. In 1989 a second dinner was held at the General Medical Council by invitation of the President, Sir Robert Kilpatrick. The guest of honour was Dr Ted French, a Guy's man who moved to Edinburgh and had been one of Sir Robert's teachers. Word got round and the dinner was supported by over 50 people including many from the years before and after 1944. Since 1990 we have met annually in the Robens Suite at Guy's. Guests have included, Lord Butterfield, Mr F R Kilpatrick, Dr Wolf Tillman, Dr Bob Knight, Dr Kenneth Maclean and Professor Cyril Chantler.

We now span the years 1939 to 1947. Those who have been to the dinner are welcome to invite any friend who is a Guy's man. The latest dinner took place on 18 October 1993. 54 people came including Bill Jeanes from Canada, Donald Paine from USA and Bob Burn from Scotland. Our two guests of honour were Dr Michael Price and Professor Maurice Lessof. One recalled Guy's as we knew it and the other discussed the future. Present at the dinner party were F J Aumonier, H L Backhouse, F B S Barkworth, A Batty Shaw, A J Beale, J P M Bensted, P Brightwell, R R Burn, A C Campbell, D N Carnegie, M B Conran, E H Couper, D Davies, S Davis, C J Earl, G M Evans, M E Evans, J M Fabricus, M M Figgis, T R L Finnigan, J Fry, J M Hall, I D Henderson, S M Hilton, P Hopkins, S L O Jackson, J G P Hutchinson, R E Irvine, A L Jeanes, C W L Jeanes, J L Jenman, C L Joiner, F R Kilpatrick, F R S Knight, A B Lee, M H Lessof, T L T Lewis, K S Maclean, N L M MacManus, R I McCallum, W B D Maile, D T H Paine, B H Pentney, T M L Price, J A Riddle, C G Roberts, D R S Saunders, W Homer Smith, I T The, W G Tillman, D Q Trounce J T Woodall, R M Woodside and L P J Wright.

Next year's dinner will be on Monday 17 October 1994. Any Guy's man who thinks he might enjoy the company of old friends and fellow students in an intimate setting is welcome to contact me for further information. My address is Dr R E Irvine, Dolphin House, Le Foulton, St Peter Port, Guernsey GY1 1YY (Tel 0481 723298).

Yours faithfully,

R E IRVINE
Dolphin House,
Foulon Road

Trust news

An appraisal of the options for the future of Guy's and St Thomas's has been submitted to Virginia Bottomley, Secretary of State for Health. The Trust has concluded that while it is physically possible to concentrate services on either site, this would not represent the best strategy for the Trust, the patients, teaching and research needs.

The overall decision is to develop St Thomas's as an acute general hospital and Guy's as a leading tertiary care centre. This will mean a radical redistribution of services such that the majority of services will be located on one site.

St Thomas's will be the main centre for accident and emergency provision, acute medical, surgical and maternity care. At Guy's Phase III--Philip Harris House--has been designed as a state-of-art facility for the provision of specialist tertiary care with integrated out-patient, in-patient, research and teaching facilities. It will become the main centre for specialist care in London.

A major new neuroscience centre is also planned which will incorporate services currently provided by the Brook Hospital, the Maudsley Hospital and Guy's and St Thomas's. The London Implementation Group's Specialty review of neurosciences recommended that the new regional neurosciences centre should be at Guy's.

The Secretary of State for Health is expected to respond to this proposal and ask for a formal consultation on the proposed changes. The necessary changes can be completed in two years, if approved.

What is a bed?

The annual Plain English Awards took place in London on 6 December 1993. The Plain English Campaign's booby prize winner was the following definition of 'a bed' by the NHS Directorate (as reported in the Independent on 7 December 1993)

'A device or arrangement that may be used to permit a patient to lie down when the need to do so is a consequence of the patient's condition rather than a need for active intervention such as examination, diagnostic intervention, manipulative treatment, obstetric delivery or transport. Beds, couches or trolleys are also counted as hospital where:

- used regularly to permit a patient to lie down rather than for merely examination or transport (eg in a day surgery ward)
- used whilst attending for a specific short procedure taking an hour or less such as endoscopy, provided such devices are used only because of the active intervention and not because of the patient's condition
- used regularly as a means of support for patient needing a lengthy procedure such as renal dialysis (includes special chairs etc)
- used regularly to allow patients to lie down after sedation

NB a device specifically and solely for the purpose of delivery should not be counted as a bed'.

Articles and Experiences

Or the problems of investigations

It cannot be that long ago that I had the most respectable of Matrons that Beckenham has to offer in the patients' chair in my office. I had made the triumphant discovery that her B12 level was far too low and the first of many hundreds of Vitamin B12 injections was about to be given. I informed her as to the findings and went on about Subacute Combined Degeneration of the Spinal cord. The term 'Subacute Combined Degeneration' has always had a ring about it--like 'Subarchnoid Haemorrhage' and my beloved 'columnar ciliated epithelial cells', which have appeared before in these august columns. However, the fact that a long and unavoidably interminable series of injections is going to be necessary for however many years are left in the allotted span is not something that can be thrown off lightly, and I had-- to be honest--been going on a bit. So came the time for the administration of the injection and I readied myself--syringe in hand--when the good lady spoke:

'D'you want me to take my pants down, doctor?'

I paused for only a short time before saying:

'I'm not that kind of doctor--actually.' I held my breath. Would I get away with it--or was my number up?

'No doctor has ever spoken to me like that before,' came the reply in the most clipped of military tones.

'I'm most frightfully sorry,' I burbled. 'If you like I'll rewind the tape and we'll expunge that bit.'

'Oh, no, no,' she interjected. 'I liked it!'

So began a most fruitful series of Vitamin B12 Injections and we have got on famously ever since.

The ancient art of investigation

When I started out in 1971 I made my first diagnosis of Pernicious Anaemia in my Father's office using an old German Haemoglobinometer which Frank had bagged off the Germans during the war. A squint down the microscope revealed the macrocytosis and so the treatment began. The man in question was of a lemon yellow complexion and had developed angina on effort--particularly noticable when climbing the stairs to his flat. We never thought to measure his B12 levels because that kind of thing was not a routine

procedure in those days. The ECG had not told me very much and I got to hate the thing quite early on in my medical career. I wonder how many of my readers have ever stubbed their toe on a Cambridge Transrite-5? It was a heavy box of tricks and a real beast to lug around the practice. One of the last times I ever used an ECG was when a very pleasant elderly gentleman came to see me. Just for once it gave a splendid trace but not before a moment of alarm had crossed my patient's face. It was a black box and for some reason he associated this with one of those 'magic boxes' associated with the contentious subject of 'Radionics'. As the whole business of Radionics lies right outside my field of experience, I am reluctant to say much about it except that--as far as I am concerned--it is the biggest load of twaddle I have ever heard of. However, I should point out that a group was set up in 1922 under the chairmanship of Sir Thomas (later Lord) Hoarder to investigate 'black boxes' and in the first test twenty-five successive trials were successful. Fellows of the Royal Society of Medicine in London were not so sure whether they should even listen to a report on such a cranky subject. However, only the other day we had a speaker at my Rotary Club, a very sensible and successful interpreter with a high security clearance, who is using a pendulum in her 'night-job' as a Humanistic Astrologer. As a third generation medic, I have been steeped in proper doctoring for so many years that anything like this brings out the very worst in me. I find it extraordinary that sensible people can become involved with such rank acts of quackery; I do hope I am not alone in this attitude.

'The ECG had not told me very much and I got to hate the thing quite early on in my medical career...a magic box associated with radionics'

To return to this patient, who, by now, had been successfully attached to my ECG machine; it transpired that his ECG was not quite right and auscultating his chest revealed a really cracking aortic incompetence and there was that Corrigan pulse thing and his neck bulged with every heart beat. He was keen to discuss his beloved Radionics and I was too polite to interrupt--so I got to hear about it anyway. Why it is always me 'they' have to come and see about these things has always baffled me. Only the other evening I was shown a photograph of a patient who had been to some alternative healing type exhibition and had a picture taken of herself with the 'aura'. I thought an aura was something that happened before a fit but it is quite evident that we have all got one--so that seems to be that.

The upshot of this cardiac case was that I never saw him again, but some two or three years later I saw a relative of his who told me that he had died. He had gone to have an aortic valve replacement somewhere--not Guy's of course--and they had never got him off the table. I'm sure that all those boxes of electrical equipment must have been too big a temptation for the fellow's mortal soul and it must have taken a dive down the wires leaving the body corporate for the coroner's pathologist to ponder over.

The end of the ECG

As for my relationship with the ECG, it ended with a visit to the physiotherapist. I had been visiting a patient who was one of the first of my psycho-neurotics. One of the disturbing things about neurotic patients is their amazing ability to divine when all is not well with their medical attendant. I wonder whether this is why our hearts tend to sink when they ring up on the phone?

'One of the disturbing things about neurotic patients is their amazing ability to divine when all is not well with their medical attendant'

The solution to heart-sink cases is to ring them before they ring you. Ah, I hear you say, but how do you know when to ring them? The answer is quite simple: you ring them regularly and have a rule with yourself to keep the conversation to under a minute. This is how the busy GP stays sane and on top of the game. I believe there are thousands of us who have discovered this for ourselves but I offer the solution for any colleagues out there who may feel at something of a low ebb. This patient spotted all was not well with me in a trice:

'What's the matter, with you, James? You don't seem yourself.'

'It's this blasted ECG. I've been lugging it out about the practice again.'

'Go and see a osteopath,' I was told. I thanked her and after a mercifully short conversation I dialled Herbert William, the physiotherapist, who saw me almost immediately. Herbert had been blind for at least forty years when I went to see him and his skill was legendary. I lay down and was getting quietly lulled into a very relaxed state when there was a most awful bang in my head as he whipped it round.

'Stone the crows...!' I began. Herbert laughed reassuringly. I saw him once more--and never did another ECG again.

Many years ago there was a superb Cardiologist in London called Dr Paul Wood MD FRCP. One day, in Harley Street, he had wired up one of our patients to his ECG machine and set it running and then he had to go into an

adjacent room. Unfortunately, our patient went into ventricular fibrillation whilst Dr Wood was in the next room and when he returned it was to find that the bird, as it was, had flown. However the trace was there for all to see and it appeared in the text book Dr Wood wrote on his subject.

The difficult problem of disposal

If you have ever had a patient die on the premises, you will know just how difficult the question of disposal becomes when there is a room full of patients waiting to see you. Harley Street is somewhat more difficult than most and we heard that the good doctor had something of a hard time deciding what to do with this deceased patient whilst he proceeded earning his very adequate crust. At the end of July last year, I had a similar sort of event but in entirely different circumstances. My patient had expired whilst sitting in the bog. It was peaceful and it was 7am. I dressed quickly and made my way to the house. His wife was distraught even though she had ample warning of what was to come. This couple had had a hard time of it what with both of them being registered blind.

'Can't you move him, doc?' I was asked.

'Not in these trousers.' I replied. 'Let the Undertakers do it for us.' I thought no more of it and then his widow said,

'I wanted you to move him because I wanted to use the toilet.'

'Ah!' That put a different complexion of things. 'Why don't you go over the road? You can tell them what's happened and then avail yourself of their arrangements. We can't have you being incommoded.' I added--as an afterthought.

This old gentleman had had a very good innings and was well into his eighty-eighth year. He had a most touching faith in me and would summon me back and forth by an hour at the changes of season--and eventually his teeth started to come loose. It was then that my ability as an amateur dentist was called into play. My first extraction seemed to be an invasion of territory that was not mine to invade; still I made a passable fist of it and pulled the lower incisor out with very little trouble. Two more followed and my luck held; no dry sockets--and no bleeding. I must say that until I'd pulled my first tooth I never knew the exhilaration of getting it right. Having lost so many of my own now, I am indebted to the Penge Dental Laboratories who have made more crowns for me than most--to such an extent that when I am finally called to that great clinic in the sky, I have instructed my undertakers to get them to put a drip tray under my head so they can get their money back on the large amount of gas that will be needed to consume my expansive corpse.

Weight and an excess of it

Weight and an excess of it, forms a measurable proportion of a Family Doctor's Life. I have already mentioned the metaphorical Miss Evans who had not stood on a set of scales for years and broke mine when she came to it. I have another patient who carried all before her in no uncertain fashion. Such were the titanic proportions she had reached that my BP cuff no longer went round her arm and there was little I could do when I did see her except look in her eyes with my ophthalmoscope, her ears with my auroscope and her throat with a torch beam. My stethoscope tended to get lost in the mighty skin folds of her torso and when that dreaded day came when she needed to be examined down below I flinched at the prospect of what was to come. I opted for a home visit but had not reckoned with the veritable menagerie of pets she had under her very substantial wing. The consultation had to take place on the ground floor when we came to it because she had found the stairs were finally beyond her and she had a bed thoughtfully laid out in the middle of what had once been a dining room. She was unwilling to lie down and when I came to look at her she was of a cyanotic hue. Her pulse was on the fast side and somewhere down in her chest was a selection of heart sounds, which, if I could have heard them clearly, would have amounted to something of a summation gallop. My survey of the scene was a bleak one and my suggestions were not very helpful to her. 'You could go into hospital,' I suggested, 'but you'd have to walk to the Ambulance. Or you would collapse and die suddenly in which case they would have to remove the front window and load you into a JCB whereupon they would take you to the local Undertakers. 'Or,' I went on, 'there is the other way...' I paused.

'My stethoscope tended to get lost in the mighty skin folds of her torso'

'The other way, doctor?' she said. I paused again--for dramatic effect.

'Yes - the other way.' I went on. 'You really must find a way to weigh yourself, and you must take some of my pills, and I want a phone call each day with the tidings as to your weight.' I went on as to my theory that a railway sleeper laid across two sets of scales would give an accurate reading and the adjustment of the scales so that they both read zero--BEFORE she stood on them--would give two sets of readings which could then be added together. She went on to lose eight stone and at the time of writing is alive and well.

James Pitt-Payne

Medical aspects of graphology

Analyses and their suprising accuracy

Having retired fairly early from both medical and dental practices I decided to study graphology and have so far devoted over ten years to this incredibly absorbing subject. After only a few weeks it is quite possible to do basic analyses and to prove their surprising accuracy. For instance, fairly early on I was asked to look at a letter written by a woman to an ex-Guard officer. Amongst other things I was able to tell him that the writer was sexually frustrated and was the victim of a pulmonary disorder of some sort. He said 'My God she's my mistress and she suffers from asthma.'

Graphology is a big subject and in the following an attempt is made to give just an outline of some of the medical aspects in a condensed form, but sufficient to whet the appetite.

Graphology is the scientific analysis of handwriting for the interpretation of:

- Character and personality
- Health and disease
- Career selection
- Personal selection
- Honesty and integrity
- Criminality
- Forgery
- Modification of character and personality (Graphotherapy)

Graphonomy, as it is sometimes known, is based upon international University research and is widely held to be as accurate as an electronic calculator, but its origins date back to ancient Europe and China.

Shakespeare said, 'Give me the handwriting of a woman and I will tell you her character.'

Definition.

The highly complex neuromuscular mechanism used in handwriting has to be synchronised to a very high level to produce normal handwriting, and is therefore very sensitive to variations in mental or physical condition. People frequently point out to me that their writing frequently changes, as if to suggest that this makes them immune from analysis. The reverse is the case because even a passing change of mood

will cause this very change and this is quite simple to prove in the laboratory. The slightest deviation can be detected just as one false note in a concerto is clear to the trained ear. This is the basis on which enormously valuable medical information can be discovered. This information is frequently sufficient to be instrumental in saving lives; usually by way of detecting the specific evidence of a failure of the neuro-muscular mechanism.

Very early warning of disease becomes evident in handwriting because the delicate communication system and the complex anatomy of the hand quickly become impaired by any deviation from the norm.

Cancer

Alfred Kanier who fled Vienna to escape the Nazis continued his work on the early detection of cancer. After thirty years of research the sceptics were surprised to find that by examining handwriting under a microscope he could produce a success rate of 70-80 per-cent. The odds against this being due to chance are about one in ten million. Furthermore this method can detect the early presence of cancer, sometimes even years before it can be by more orthodox means. In this work he was assisted by Dr Daniel Casten and they investigated 10,000 cases and the result led to a massive screening program funded by the American Cancer Society. The system is now used in many American Hospitals. His work was eventually recognised, and he was appointed to New York's renowned Strang clinic.

This system is also used successfully in the detection of the incipient heart disease and many other serious conditions. This has indeed come within my own experience.

Unacceptable levels of stress are very common these days and the effects are readily discernible and the measures to counteract them are easily monitored.

Murder

Murderers generally seem to have very similar characteristics in their handwriting, so that, given a pile of papers, it would be fairly simple to pick out the one written by a murderer. Less serious matters can also be detected without much trouble; such as criminal tendencies in general and dishonesty, but then all the complexities of character and personality are embodied in everyone's handwriting. Even the handwriting of the disabled who have to write using their toes or their teeth still shows the same signs in their writing as they did before the disability.

Sex

The show-biz symbol can usually be shown to have low sex drive whereas the rest of us who may seem to be quite ordinary frequently turn out to be anything but!

These and other areas of graphology are invaluable in the analysis of personal compatability, as might be expected, but care has to be taken. For example, a Y looking like the figure, might lead you to think the subject is a lesbian when in fact it may alternatively simply indicate an interest in literature!

Angst

Dr O L Harvey of Boston discovered an association between angst and narrow upper loops combine with overlap of lower loops and the line underneath. There are many other indications with which to confirm these findings.

Emotional disturbances

Professor Eyesck produced a detailed picture of this condition from graphical analysis. In this he found that in these cases the subject tries to curb the emotions and this shows up in the curtailment of various impulses in the handwriting.

Drug treatment

Professor H J Hearse of Germany uses hand writing to assess the effect of drugs on the treatment of medical illness.

Alcohol

In Sweden and in the United States a sample of hand writing and urine is required in suspected drunken driving. It is also widely used in the diagnosis of alcoholism and graphotherapy is sometimes used in treatment.

Dr Neils Riesby of the University of Copenhagen has analysed the effects of alcohol on handwriting.

Dr Clarence Tripps of the state University of New York's alcohol Clinic investigated the reversal of the usual pattern of deteriorating handwriting due to alcohol. He established that the handwriting of alcoholics appeared like that of normal drinkers when they were intoxicated! As they became drunk, however, alcoholics' handwriting steadily improved until it resembled that of normal drinkers who are sober.

Psychiatry

Dr Donald Douglas, chief neurologist at the Lenox Hill Hospital and also Green and Lewis, authors of 'The Hidden Language of Your Handwriting' have shown that a number of handwritings can be positively linked to mental health problems.

Graphotherapeutics

Paul de Saint Colomb, a war hero who had degrees in philosophy, literature and law was also a graphologist. He found that you can correct your worst faults and strengthen your character by changing your handwriting. This proposition was put to scientific investigation at the Sorbonne in 1929-31 by Dr Pierre Janet and Professor Charles Henry; neither was a graphologist. This method can be dramatically successful in adults. In over indulgence, for example alcohol, the use of stronger T bars can produce the desired result.

Children

Dr P Oininen of Finland's Jyaskala University specialised in Experimental investigation of behavioural problems, and similar studies form an integral part in educational assessment; and the same is true of France, Germany, Holland and many parts of the United States of America. Of course it is the writing and not the content which is important, as with adults.

Emotions and ink colour

We can be white with rage, green with envy, have a yellow streak, be in a black mood, feel blue and see red. Dr Williams Rottersman, for the United States Marine Corps, showed that ink colour alone could provide a useful indicator of a recruit's suitability for military service. His research revealed that while there was a rejection rate, on physical grounds, of only 10% of men who habitually wrote in blue-black or black ink this rose to 50 per-cent amongst those among those using green ink by choice. The latter group also shared a number of distinctive emotional characteristics. These can be described at a later date. One example is that they tend to have dangling dolls in their cars!

Conclusion

Handwriting is used to indicate risk rather than diagnosis, and though very accurate, like all other methods cannot be 100 per-cent accurate. However, in some areas it is the most accurate available.

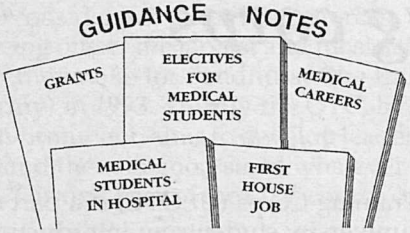
A personality and character analysis can provide deep self-knowledge. It can answer the impassioned plea by Robert Burns,

'Oh would some power the giftie give us!
To see ourselves as others see us!
It would from many a blunder free us,
An' foolish nation.'

It is said that in Switzerland the casual does not consist of a comment on the weather but an enquiry as to the latest on graphology. At any rate, the subject throughout the developed world is recognised as useful in many spheres, and in the US, most multi national Corporations invest large sums on the graphological analysis of prospective employees, and it is not at all likely they would do this without very good reason.

Dr J C Matthews

BMA



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Officer training corps

Stretching mind and muscles

The University of London Officer Training Corps (ULOTC) is a part of the Territorial Army which gives university students an introduction to life in the army. I went along to my ULOTC interview attracted by the lure of cheap ski holidays. Not having had the benefit of a combined cadet force training at school, all at the OTC was a culture shock--right from day one. Any ideas of a cosy 'tete a tete' with the commanding officer over tea and biscuits, as I told him of my suitability for the OTC, were rapidly dispelled. Gruelling hours of copious form filling, sizing for uniform, a medical and a fortnight of intensive interviewing were nearer the reality. On the final day I met a kindred spirit whilst waiting for my interview--an ardent skier and mountain rescuer. Our conversation started with the rather obvious question 'Why do you want to join?'. He decided to try out my reply in his interview. For some reason his interviewer, moulded by years in the British Army, was not overly impressed to be informed by this strapping young lad that his main motivation for joining the OTC was he found men in uniform irresistible. Those of us who had survived so far (ie phase one) and who had not been discouraged by the CO's address--a stirring piece which made one proud to be British and informed us of the high level of commitment and dedication required of a member of the OTC, then went on a selection weekend. This aids the whittling down of 900 or so applicants to the 200 who would eventually be accepted. It included a series of command tests, designed to reveal our superb(?) leadership qualities by coordinating our team to remove landrovers from ditches or carry heavy tractor tyres over assault courses.

Some of the more cynical reading this article may be wondering why the Government sees it fit to fund the OTC out of tax revenue. Firstly the OTC provides reserves for the army--trained individuals who may be called into

action in times of national emergency. Secondly it encourages young people to consider a career with the forces. The London OTC is proud of the fact that, being one of the largest and most active units in the country, it provided three of the intake for Sandhurst (the training ground for all officers entering the army) in 1993. Thirdly the OTC, by providing a challenging and stimulating environment, aims to develop leadership qualities in young people which will stand them in good stead whatever their chosen career.

The first year of the OTC course consists of weapons training, drill, nuclear, biological and chemical warfare and first aid--taught at basic squaddy level. The second year concentrates on the skills required of a platoon commander in formulating basic battle plans and the third year provides an opportunity to put these skills into practice within the unit. Teaching takes place on one evening a week and on about one weekend in four.

My friends have been intrigued to know why I have endured the OTC for one year--miserable, cold frosty nights on Salisbury plain shivering under a poncho...lying awake for hours on stag duty at three am, looking for enemy movement...awakening at 0500 hours to do some form of vigorous physical torture such as the dreaded stretcher run through the dark across mud...being persecuted for the tiniest of creases on my shirt or dull boots despite of sacrificing the previous evening to pressing and polishing my kit...not to mention the time commitment on top of an overloaded curriculum and active medical school life.

The number one factor for 'sticking with it' has to be the superb people I have met. It is highly refreshing to step outside of the medical school and meet students from other disciplines. Successful OTC functioning relies upon a cohesive unit and so social activities are frequent, such as balls, cocktail parties and official dinners, as well as a well subsidised bar in the Officers' mess. I have also the chance now to consider a career in the British Army Medical Corps, a fantastic opportunity for those who are looking for something different and who would enjoy taking on the responsibility for the health of an entire regiment. It is not,however, necessarily the best of choices for those wishing to pursue a career in hospital medicine alone. Last, but not least, the extra money comes in useful supplementing student grants, although most people appear to spend it in the bar

Once the minimum basic military training requirements have been fulfilled a number of perks are available. I have had a week of downhill ski-ing with top-class instruction, followed by a week of cross-country ski-ing, spending two nights in a snow hole, instruction on mountaineering techniques and been on a mountain leadership training course in Glencoe. As well as this I have spent two weeks in Bavaria--the first as an instructor for climbing and mountaineering and the second white-water canoeing.

I have enjoyed my first year with the OTC immensely and would highly recommend it to anyone who is prepared to take the challenge.

Annabel Nichol

GUY'S HOSPITAL BIENNIAL DINNER

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Can I take this opportunity of reminding all readers about the 1994 Guy's Hospital Biennial Dinner to be held on the first Friday in October, as usual. Further details will be announced later, but anyone wishing to attend should contact Mrs Barbara Ingarfield in the Medical Director's Office at Guy's Hospital on 071-955-4169.

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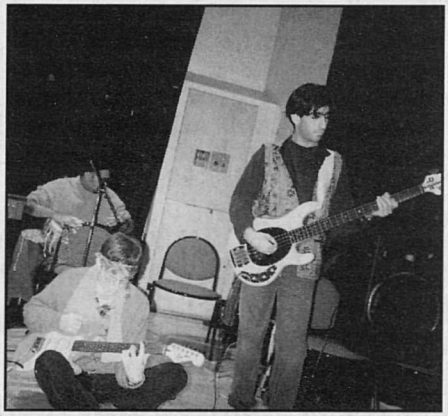
The Diwali Show

Entertainment international style

The Diwali show was the first show this year that the International Society put together and to state the obvious this year's show was a roaring success. The curtain rose to the reverberating sound of ABBA as East hit West in a dynamic fashion. The band, which was fronted by the very talented trio of Gita, Saloni and Emma, performed 'Dancing Queen' and a couple of disco classics. The rest of the band (in particular Hugo Wilson) in outrageous costumes, reminded the audience of those 'good old 70s days' and gained an instant groupie following.



The lively comperes, Bal and Salima, led the audience through a myriad of cultural experiences from classical Indian dance, to tongue-in-cheek humour and catwalk style fashion shows. Especially enjoyable was the 'This is your life!' sketch written and performed by Harry and Pankaj. However, it was Niifio who brought the house down with a most incredibly seductive wiggle of the hips, whilst wearing a Sari and speaking in Gujarati.

Same other unforgettable moments included the entrance of 'smooth' Sam Singh on to the stage as the lead vocalist of his pop group, Saloni singing the very beautiful Hindi song 'Ye Vadan Rahan' and the miming and dancing of both Pankaj and Srikanth in a visually stunning and romantic song-and-dance routine, aided by Debjani and Sunita. I also especially enjoyed an Eastern

interpretation of Michael Jackson's 'Who is it?', which was both imaginative and atmospheric.

No show would be complete without a technical hic-cup. This evening's one occurred when the music to the Bungra dance failed to start properly. However, at the third attempt, Daljit, Bavini, Raja and Imran rescued the situation with an extremely entertaining dance. The audience loved it so much that the song was played once again in the Hop.

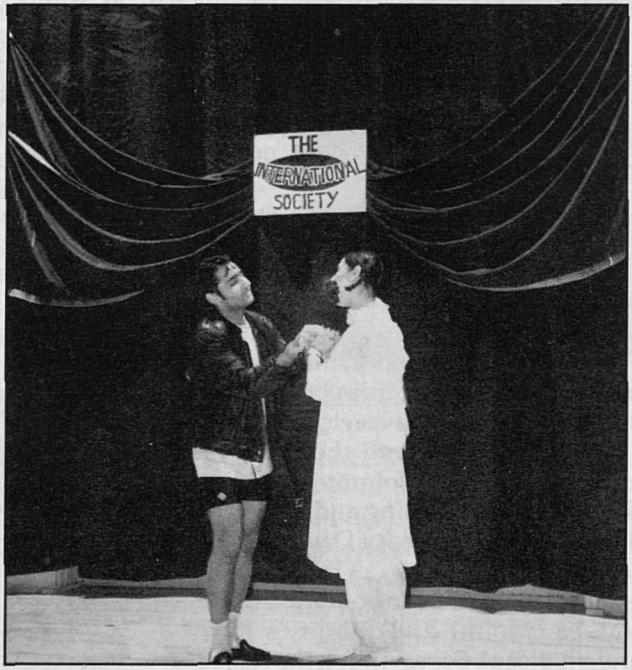
The fashion show, masterminded by Susan and Daljit, included a very professional catwalk (both Dipalee and Sunil appeared to be very popular) as well as a very moody and stylish display of ladies' evening wear and an intriguing dance routine to 'Delicate'. The biggest cheer,however, went to Dharmesh as he casually received the attentions of his four supermodels.

The undisputed highlight of the evening was the musical re-make of 'Grease'. The audience sat enthralled as the relationship between Pinkie (Pamela) and Johnny (Jayesh) ebbed and flowed against the romantic(?) backdrop of The Spit (The Spitter) and Guy's Bar. Superb cameo performances from by Vikram, as the 'baddie with the fancy wheelchair' and the members of the 'T-Budds' and the 'Pink Jilebi' gangs. However, Jayesh (as Johnny) was the star of the night, combining dancing and comedy-acting with hilarious impressions of David Attenborough and Chris Eubank.

The plot culminated in a confrontation between Pinkie's father (Molin) and Johnny's parents (Monica and Shaheen). Sure enough the caste system reared its ugly head again and Johnny's proclaimed love for Pinkie was met with the inevitable cry from his parents of, 'You will love nothing but your books.' Credit must go to both Monica and Tejal for their excellent script and choreographing of the play.

Having not encountered the varied delights of the Asian culture before, I particularly enjoyed the whole experience. I have only been able to mention a few of the people involved, but everybody was a 'star' on the night, from the classical dancers, the musicians and the actors to the light technicians. The organizers, Anesh and Dharmesh, are to be congratulated on the smooth running of the show--something which required weeks of preparation back-stage before the big night. It was also particularly delightful to see so much talent amongst the students. Congratulations to all involved.

Julian Barwell



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Frank B West

Over 49 years of service to Guy's

On 21 September 1993, in the Large Committee Room in the Medical School, friends and colleagues gathered together to bid 'farewell' to Frank West who was retiring after forty nine and a half years continuous service at Guy's. Frank West began his career at Guy's on 15 May 1944 as an apprentice in the Medical School Workshops. After 4 years he had completed his indenture and was immediately transferred to the permanent workshop staff. In those days the workshops were sited on the lower ground floor of the Medical School where they remained until 1973, when they transferred to a much larger purpose-built suite of rooms on the ground floor of the Nag's Head Yard extension.

When, in April of 1972 E G Smith retired, Frank was the obvious choice to be appointed head of workshops, a post he held until his retirement. He served under six Deans and Principals, the first being T J Evans, and four Secretaries, George Winston, W F Cook, Donald Bompas and Simon Argles. He saw the workshops change their function from a small facility for the repair and maintenance of apparatus used for practical teaching classes in the pre-clinical departments, to a workshop for the design, construction and development of scientific apparatus and machinery for pioneering medical and surgical research. Examples of this aspect of the work of the workshops are the hypothermia machine and the heart-lung by-pass machine used in the open heart work of Lord Brock and Donald Ross and the prototype dialysis for Renal Unit.

In recognition of this important change in the function of the workshops, the Council of Governors accepted the recommendation of the School Council that the title should be changed to The Medical Scientific Workshops. This change also identified the fact that an increasing part of the workshop's load was coming from the Dental School which was rapidly becoming recognised as one of the premier dental schools in the world for teaching and research.

At the height of the workshop's activities Frank West was responsible for a team of six engineers, which included two juniors for whose training he was totally responsible. The staff were always kept extremely busy with the design, construction, development and modification of apparatus required to satisfy the ever increasing research needs of the Medical and Dental Schools and of the hospital.

Frank West proved to be an outstanding head of workshops. His professional skills and experience were unsurpassed in all aspects of scientific apparatus and instrument engineering. He had an expertise in the use of a wide range of materials including plastics and more than a passing understanding of electronics. Not only was he highly skilled in the use of a wide range of machinery but he had a remarkable gift of being able to teach others those skills. Frank, however, will freely admit that his passionate interest is clocks and their restoration and maintenance. Indeed, testimony of this interest, much encouraged by people such as Donald Bompas, is to be found in the selection of very fine old clocks in excellent working order which are strategically sited in and around the Medical School. It has to be recorded that his clock interests were further extended to include 'security' when some years ago several valuable time pieces were stolen.

Frank always appeared as a modest and unassuming person who, at all times was kind, courteous and helpful to anyone who sought his advice and assistance. It did not matter who you were, a professor heading a large research team or a student engaged in a undergraduate research project, the welcome in the workshop was just the same, the beaming smile and the question, 'How can I help?' Whatever the problem, whether it be the design of an instrument to accurately insert intra-cranial electrodes or to provide a wedge shaped piece of wood to keep the laboratory door open, it would receive the same full, undivided and unhurried attention.

Frank West has a tremendous love for Guy's and all it stands for, an affection which withstood severe testing during his last few months before retirement. This was the decision to close down the Scientific Workshops in the Nag's Head Yard extension and merge with the hospital workshop in the basement of New Guy's House. There can be no doubt that the closure of this unique facility, the envy of other medical and dental schools, which Frank had himself had set up way some 20 years before, must have caused great hurt and disappointment. However, as Simon Argles pointed out at Frank's retirement party, he accepted the decision once it had been made, with fine spirit and co-operated to the full in the transfer, storage and disposal of the machines and materials.

Frank West retires with the thanks and good wishes of his many friends and colleagues at Guy's who, over almost 50 years, have experienced the quality of his professional skills, enjoyed his friendship and admired his unflagging loyalty to the Medical and Dental Schools and to the hospital to which he has devoted his entire working life. To Frank and his wife, Jean, we all wish a long, happy and healthy retirement.

M N Naylor

Immunology

Essentials of Clinical Immunology. Helen Chapel and Mansel Haeney. Blackwell Scientific publications.Price £18.50. Third edition.

I was more than pleased to be offered the chance to review this book, as it coincided with the onset (onslaught?) of path in September, and I was therefore able to keep my copy handy for those sticky moments which occur all-too-frequently with Immunology. As anyone who has just done the course knows, 'Essentials of Clinical Immunology' is of the must-haves. Immunology is a rather mysterious subject, well over the heads of most of us lesser mortals; hardly has one got to grips with the varying functions of T-cells and B-cells than one is expected to apply those first principles to Hasimoto's thyroiditis, Reiter's syndrome and the rest.

Anyway, luckily, 'Essentials of Clinical Immunology' makes it all crystal clear. The text is well-explained, easy to understand; and nice and large too--easy on the eye--of especial importance in relation to those late night cramming sessions. There is also a very useful chapter at the beginning of the book which recaps on the basics for all of us who had forgotten all about T and B cells; in addition each chapter carries case studies of unfortunates suffering ailments of interest to immunologists.

Also of great use are the multiple choice questions at the end of each chapter, designed to let you find out just how much of the last few pages you have understood; very useful indeed since, believe me, the immunology MCQs in the path exam are not for the faint hearted.

Finally, for those of you who like to leave nothing to chance, you may be interested to hear that Helen Chapel is usually one of the external immunologists conducting the pathology vivas; so it might be worthwhile buying the book just so you can tell her what a jolly good read it is yourself.

Haematology

Haematology. Pathophysiologic basis for Clinical Practice. Edited by Stephen H. Robinson and Paul R. Reich. Price £29.95.

Now, I have to say this book didn't look half as well-thumbed as my 'Essentials of Clinical Immunology' by the end of the path; mainly because it was written by a whole host of frighteningly clever professors from Harvard who took a rather deep interest in haematology--or hematology, as they would have it, than I needed. Having said that, it's an excellent reference book and if you're all at sea over the overlaps between leukaemias and lymphomas (always a bit of a grey area as far as I'm concerned), and you are prepared to wade through several pages of rather small and detailed text, then this is the book for you. The book's best feature though, is it's excellent photographs; fourteen pages' worth of teardrop poikilocytes and Reed-Sternberg cells, to name but a few. These pictures alone make the book worth having; though, if it's a basic text you're after, you would be advised to look elsewhere.

O. Mc Ginn
4th year medical student

First aid

Cardiopulmonary resuscitation. D V Skinner, R Vincent. Oxford University Press £14.95.

This book is part of the Oxford Handbooks in Emergency Medicine series for Accident and Emergency staff, in particular junior doctors and nurses. It comes at a time when many researchers have shown that training for cardiopulmonary resuscitation needs improvement and the European and UK Resuscitation Council Guidelines have been rewritten. It covers management of cardiac arrest, special causes of cardiac arrest, acute myocardial infarction, ventilation and intravenous cannulation, common arrhythmias, the biochemistry and pharmacology of cardiac arrests, paediatric resuscitation and post-resuscitation care.

Its major advantage over other books is that it is up-to-date, with the latest European and UK Resuscitation Council Guidelines. These are reproduced inside the back cover, very useful for quick reference. The book is well set out with a good mixture of text, algorithms and drawings. There is helpful cross-referencing throughout the text.

The management of cardiac arrest is simply and clearly described. The distinction between witnessed and non-witnessed arrests is rightly made. These are helpful suggestions for the organisation of the cardiac team. Perhaps the need for speed when initiating defibrillation should be emphasised as survival rates fall significantly if defibrillation takes place more than three minutes after the cardiac arrest. The chapter concerning possible causes of cardiac arrest is useful, with a helpful algorithm for the management of pulmonary emboli and a list of the UK Poison Centres telephone numbers. Management of acute myocardial infarction is clear and up-to-date, containing a useful comparison of thrombolytic agents and a good use of boxes to outline important points.

The chapter on ventilation and intravenous cannulation contains good points such as the emphasis on needing two people for effective bag-value-face mask ventilation. It is sometimes difficult to see what level of experience in the reader is expected by the authors. A detailed description of insertion of a Guedel airway is given but the vital neck flexion and jaw thrust essential for maintaining a clear airway is only mentioned, not described. Intubation is described, but if the reader cannot intubate do we want him or her to try? It is better to maintain oxygenation by face mask than to suspend it during unsucessful intubation attempts.

Management of common arrhymias is discussed clearly with pictures and clear guidelines. The biochemistry and pharmacology of cardiac arrest is excellent, incorporating discussions of the dangers of bicarbonate and the role of oxygen. The chapter is a useful summary of the aspects of post-resuscitation care often not covered in resuscitation teaching.

In conclusion, the book is a concise guide to the management of common cardiac emergencies and should successfully help the junior staff for whom it is designed. The subject is covered thoroughly yet the book is small enough to fit in a pocket. It can be read in a sitting and is a useful quick reference book. It is up-to-date with all the recent recommendations.

U Hodges
Department of Anaesthetics

Joan Mary Smith

Joan Mary Smith, a former student and nurse at Guy's Hospital died on 29 August 1993, aged 59 years, after a long illness, bravely borne. After her training on the wards she concentrated on operating theatre nursing under theatre superintendant Margaret Laws, now Helliwell, at the time that Russell Brock was carrying out heart by-pass operations. In the words of Margaret Laws, when Joan Mary Smith (then Loveless) left Guy's in 1958, she was, 'an excellent staff nurse and a very good friend...who was going to be a great success'. Mrs Smith maintained her connections with Guy's and was a member of the Nurse's League. Below is the address given at her funeral.

We are all here today to remember Joan and how she shared her life with us. We must all treasure our own special memories and remember how bravely and courageously she fought her illness right to the end.

Joan and her husband Roy had three daughters of whom she was very proud, Jenny, Marilyn and Sandra and three grandchildren, Daniel Shaun and Faye, who gave her so much pleasure. We all pray for Roy, who was a tower of strength and a great comfort to her throughout her illness, and Jenny, Marilyn and Sandra to help them throughout this very sad time.

Joan always stayed in touch with all friends she made during different times in her life and I'm sure many of you are here today. Over the years Joan lived her life to the full. A loving wife and devoted mother Joan was always full of enthusiasm for everything she did. In her life and travels she had done and seen wonderful things which gave her great happiness.

Joan was born in Budleigh Salterton, Devon, in 1934. Her family moved to Wivenhoe just before the war when Joan was four. She loved Wivenhoe and was involved in all the usual local activities, sailing and cricket being two of her favourites. Her interest in cricket, started by playing with her elder brothers Don and Ray, was also encouraged by being related to Dennis Compton. She remained keen through the years often going to test matches and enjoying county cricket at Chelmsford.

Joan went to school at St Mary's Convent School in Colchester. After leaving there she gained a place at Guy's Training School in London and trained as a nurse, qualifying as a SRN in 1957. After working in the operating theatres at Guys she moved back to Wivenhoe and joined the theatre staff at Essex County Hospital in 1959 and became a Theatre Sister shortly after.

On 5 September 1959 she married Roy in Wivenhoe church and they then set up home together in Ardleigh, where they have lived ever since.

Joan involved herself in village life and activities and made many friends over the years. She was secretary of the Ardleigh PTA for 11 years as the girls progressed through the school. She was the local Avon lady for over 15 years and then handed over her round to Jenny. For many years she was an active member of the Keep Fit Association and enjoyed weekly Keep Fit classes and participating in displays.

She later resumed her career as a theatre sister, also working at the surgical unit at Severalls Hospital. On the opening of the new Colchester General Hospital she transferred from the theatre nursing to administration and helped to commis-

sion the new Hospital Sterilisation and Disinfection Unit as Deputy Manager. During this time she was very involved in the National Association of Theatre Nurses and although she retired in May 1991, she still stayed on as Regional Public Relations Officer and a member of the national committee, a post she was very proud of and very much enjoyed.

Another source of great pleasure was playing the accordion with 'Jenny's Accordionists', a Colchester Accordion Orchestra. She derived great pleasure from playing at concerts both here and abroad and from the many friends she made through this activity.

Joan and Roy had many holidays together, mostly in their caravan. They travelled all over Britain, often visiting friends, went to Ireland and often had trips to Europe. Joan also had two trips to America. One with the Keep Fit Association, visiting New York, giving demonstrations and one with the National Health Service to Iowa to study and improve on operating theatre techniques. Joan was very dedicated to the nursing profession. This was exemplified in her work for the National Association of Theatre Nurses on which she was so keen and courageously participated in right until the time she was taken from us.

All change

'Change and decay in all around I see', wrote the hymn-writer. Let's hope we don't see too much of the latter while having to tolerate the former! It seems only the other day that I was welcoming Maureen Theobald, in these pages, as Director of the then newly formed College, combining Guy's, St Thomas' and Lewisham Schools of Nursing and Midwifery. Actually, it was only the other day--mid 1991 to be precise. Now the College and Ms Theobald have both disappeared. Ms Theobald has gone to the ENB, where she has already been working part-time. One wonders what will happen to that body now she is there?

The College has been transmogrified into a super new institute, the Nightingale Institute, with Jill Macleod Clarke as its director. I have not interviewed Ms Macleod Clark for the Gazette, as I did Ms Theobald in 1991. I thought that maybe by the time I had waited for a bus and been transported to her office--she might have moved to another post, such is the appetite for, and pace of, change these days! So, my information about her is gleaned from a newsletter entitled Learning. Ms Macleod Clark has been director of Normanby College for two years and a professor of nursing at King's College

London since 1900. After qualifying as a nurse in 1965, she worked as a nurse and ward sister for several years. Then she returned to education, gaining a degree in Social Psychology from the London School of Economics.

After graduating she was a researcher and lecturer in nursing studies, with the University of London, becoming senior lecturer in nursing at King's in 1986. Professor Macleod Clark has an impressive track record in research--she won over £1 million funding for projects in areas such as communication between nurses and patients, health promotion and smoking cessation. At the Nightingale Institute she will be responsible for bringing together the professional expertise and caring traditions of the present Colleges of Health, with the academic strengths of nursing at King's.

Professor Macleod Clark sums up her vision for the future by saying that she will ensure the Institute lives up to the highest expectations by:

- Establishing flexible and creative educational programmes designed to enhance the quality of nursing care
- Research-based teaching leading to research-based practise
- The development of the nurse's health promotion role
- A strong emphasis on the acquisition and enhancement of interpersonal and clinical skills
- Close collaborative links between education purchasers and the Institute

This newsletter elaborates, 'Would-be lawyers, hopeful musicians and brilliant mathematicians are amongst just some of the people studying at King's. And from October, Nightingales will be among them.' Perhaps they will be heard singing in Berkeley Square? 'Nurses and midwives will be able to mix with other students and everyone will benefit from that broadening of horizons. King's College London is one of the oldest and largest Colleges of the University of London. Nightingale Institute will join some 9000 others on over 200 degree programmes in six schools of study.'

Apart from staff working in the school college or whatever name the establishment takes, some of whom will find themselves redundant, few amongst the service staff to whom I spoke were aware of the new order.

Apparently Mrs Bottomley ('Is she still in post?' I hear you ask) was delighted with the new business brochure. One factor made clear by the Institute is, 'the implication of the Tomlinson report that fewer nurses with a broader-based education and wider range of skills will be required to staff London's hospital in the future.' We thought Tomlinson was all about getting things into the community--surely this will need more nurses, not less? I would be interested to hear what the Institute has to say about this!

I know many readers of this column are retired nurses. I am sure that the heavy emphasis from King's, plus the name Nightingale, and the loss of reference to Guy's will sadden them. What advice and encouragement have they got to offer those taking up nursing as a career today? Some of you must possess optimism, please.

Denis Cobell

Men's Hockey 1993--into the abyss

With all but two fixtures left to play in the first half of the season the 1st XI was reeling from 9 losses, 3 draws and only 2 wins! As ever, the results are slightly paradoxical, with the best performances being saved for the more successful opposition teams and some of the lesser outings being played against sides who, like us, are up against it.

The season started cheerily with a 9-0 drubbing of the Vets in the UAU league (later we were deleted by the Royal Free). Other notable games were played against the President's XI and Old Cranleighans. In the former, faced by a host of very experienced (read portly) and gifted (read cynical) stars of yesterday, we were able to take the lead in the second half. This was promptly conceded again but the team played passionately to notch a late equaliser--assisted in part by extremely attentive umpiring from Guy Barwell. Against O C's an extremely moving resignation speech, by way of pre-match pep-talk from the increasingly frustrated skipper, probably had nothing to do with the spirited effort which saw us take the lead in the first half through an opportunistic and ruthlessly taken goal. Inspite of only having 10 men--a regular feature in the three weeks before pathology finals, we defended staunchly against a side placed 4th in the Surrey 1st Division but eventually let one in to clinch our only point in this league so far.

The personalities of the 1st Team:

Simon Finn, a first year medic with an uncanny resemblence to the chap in the Murphy's ads, has proved a valuable find and has been an increasingly reliable linch-pin of defence. The emergence of a more aggressive side to his character ever since a close encounter with a large man's wallet, has made a great difference to his play.

James Simkin, also a fresher medic, has impressed many (not only on the field of play) by the extraordinarily slippery way he moves his body--a great asset in attack and at hops. A haircut might enable him to emulate his look-alike Ryan Giggs even better.

Jamie Galbraith, prolific winner of the 'Tosser's Tie' (four times so far) and dedicated immitator of members of the Rugby Club should go far this season, perhaps all the way to Brighton for some more of his grandmother's home-cooking.

Dominic Paviour, has allowed Delilah to penetrate his defences (but few of the opposition attackers) with the result that his antenna has been removed. This doubtless has a lot to do with the impressively cynical and dirty tackles he has been exhibiting (keep up the good work). He also has a bizarre ritual of standing up quickly in the bath,'In order to clear my head,' he says.

The brothers Singh Mehta have blessed us with their admirable stick skills. Sampi has been rather subdued of late since taking up philosophy as a pastime. For example he turned to Mark Cynk midway through the second-half (circa 3.10 pm) against O C's and said,'Wow! Look at the sun, I wonder whether it's rising or setting?' His stick-throwing skills have also improved. Jogger, in the meantime, continues to be the team authority on matters fashionable.

Will Fellingham, the team's most versatile player and most prolific stud may well be wearing protective clothing more

often. At least that's the advice we have been giving him.

In addition to these demi-gods the team has been graced with the immortal likes of General Hover, Simon Moodie, the man with the Benign Familial Quintessential Tremor, Rob Hatrick, freshers Neeraj Bhasin, Guy Moores (I wear my sweatshirt inside-out because that way I don't have to wash it so often (?)) and Stephen Fenn. There have been many others too who I am grateful to for their support. We hope for better news in the New Year.

Tall Tom

Rugby 1st XV

Match report

Guy's Hospital 1st XV v Cranleigh. 30 October 1993. Won 28-12

On a typical autumnal day, grey and cloudy and on a heavy pitch converted from farm land, Guy's faced a young and enthusiastic Cranleigh side and showing signs of lethargy immediately conceded a try which was converted. The next ten minutes was all Guy's pressure and during this time were awarded four penalties, but none were converted. A series of good second and third phase possession led to a smart movement along the line but then back to the blind side where Ross Llewellyn put Richard Breeze over in the corner for an unconverted try. There followed a period of exciting play and pressure from the Guy's side but Jones was brought down a couple of yards from the line and Cranleigh kicked clear. A five yards scrum to Cranleigh was taken against the head, almost to the try line but unfortunately the ball squirted side ways out of control and the position was lost. Then from a short penalty move Ross Llewellyn was nearly over. This continued period of pressure left the Guy's supporters a little frustrated as the half ended 7-5 to Cranleigh but really against the run of play and the Guy's promise of many points had not been realised.

The Guy's back row of Davies, Ross Llewellyn and Ryan played extremely well, securing the ball in the loose and outside. Ed Hughes was playing very steadily at stand off and the old master in the centre, Alan Jones, showed that he could still not only launch long kicks but make deceptively fast dashes for the line. There was the occasional unfortunate incident and after Challacombe had dived on the ball and secured, a stray Cranleigh boot led to a bad gash over his eye. He was patched up and sent back on and when Cranleigh were penalised under their posts Lewis converted to make the score 8-7. From the line out on the Cranleigh line, Guy's forwards obtained the ball an a rolling maul saw Barrio driven over and the try converted by Lewis, 15-7. Cranleigh were again penalised for going over the top and Lewis kicked, making amends for earlier misses, by kicking a penalty from the half way line, 18-7. A scrum to Cranleigh was disrupted by the Guy's front row and a terrific scrum walked the Cranleigh pack back--the ball was won and Billy Challacombe made a dash to the corner to score making it 23-7. A similar move a little while later led to a line out on the Cranleigh line and a special Greek move led to Tsolkiades going over to an unconverted try, 28-7.

Just on the final whistle a series of penalties to Cranleigh reflected a loss of concentration by the Guy's side and some pressure on the Guy's line. In contrast to the splendid scrummaging earlier on, the Guy's pack relaxed and allowed Cranleigh to steal one against the head and although the ball was won, the clearing kick was charged down as Cranleigh scored at the final whistle to leave the score 28-12.

Cranleigh were formed in 1967 which makes them one of the country's newer clubs playing the oldest. They were very hospitable and after the donation of 150th anniversary their President was very complimentary about the Guy's style of play and our chances of promotion from Division three.

Team: J Burt, R Breeze, A Jones, S Lewis, G Bevan, E Hughes, R Docker, A Hyatt, D Evans, G Tsolkiades, E Barrio, B Challacombe, G Ryan, R Llewellyn, P Davies, sub A Bates.

SJC

Match report

Guy's Hospital v Eastleigh. Courage League. 11 December 1993. Won 25-3.

The morning after the Christmas Ball, Guy's travelled down to Eastleigh on yet another bitterly cold December day. With temperatures hovering just above zero, the Guy's team kept the fair-sized crowd, including many Guy's supporters, warm with an early penalty, though the deciding factor of the game was a strong wind blowing across the pitch which kept play to one half of the pitch. It was fairly equal for both sides Guy's were looking the more cohesive side, and with good interpassing and control among the forwards, supported by the boot of Davis at stand off, kept the game in the Eastleigh half. From a rolling maul Beardmore crashed over for a try converted by Neil Davis to leave the score 10-nil. There were several changes in the side with Beardmore replacing the injured captain, Ed Barrio and with Matt Rose coming, in for his first game for some weeks. The play by Guy's was extremely sound and resulted in the turn over of several balls from Eastleigh to Guy's. Alan Mislen was playing his first league at Hooker and showed an impressively fast strike. Notable were some outstanding tackles by George Tsolkiades which left much bigger forwards knowing that he was on the pitch. When Eastleigh were offside on the ten yard line, the penalty to Guy's was converted by Neil Davis to leave the half-time score 13-nil in Guy's favour.

The second half was noted for some really long touch kicks by Neil Davis, and some cunning grub kicks by Docker. Soon after half-time Phil Cunnington in the back row was replaced by Wayne Llewellyn. It was of concern, however, that we were not winning good line-out ball. Guy's were also being penalised several times for going over the top which was as much a reflection of how far we could go forward in the loose as to lack of technique. However, one of these was converted by Eastleigh to make the score 13-3. Throughout the game Guy's were much more enterprising and a superb break by Docker up the right hand side of the pitch was taken on by the centres for Bevan to score half way out but was not converted. Guy's enterprise was rewarded when Justin Birt caught the ball in his own 22 and instead of kicking to touch ran it and, with good common

sense, chipped over the advancing centres, where the full back was caught in possession, robbed by the back row and Ross Llewellyn scored under the posts. The try was converted by Neil Davis. It proved to be the final score of the match, to leave the score 25-3 to Guys.

Eastleigh RFC was founded in 1921, and the founder of the Club was Bill Saffrey who remains its President today. He was delighted that Eastleigh should be playing Guy's, and to mark the occasion of the 150th season and the match, presented to the Guy's President, Professor S J Challacombe, an engraved piece of English pewter.

Team: J Birt, G Bevan, A Jones, S Lewis, M Rose, N Davis, R Docker, G Tsolkiades, A Mislen, A Heiatt, B Challacombe, C Beardmore, R Cunnington, R Llewellyn, G Ryan. Replacements: W Llewellyn for P Cunnington.

SJC

Rugby 2nd XV

Match report

Guy's II XV v Cranleigh. 30 October 1993. Won 57-7.

The fixture card had it billed as a 3.00 pm kick-off so you can imagine my surprise at missing the first 25 minutes when I turned up at 3.05 pm. Still I only missed the first 4 try and Ronans Circus Act. Guy's were 20 points ahead following 2 trys from Matt Rose, a push over touched down by Dipper and a champagne spectacle scored by Bill Schaeffer.

The countdown to half-time allowed close inspection of the side. The team appeared to be locked in some spooky time warp with names and faces from the past littering this talented 2nd XV.

Then, as if by magic, the shopkeeper appeared. Three runs into the second-half Mark Howells scored a blistering try converted by a replacement kicker 'The Real' Roy. Stron on the right wing took the high swirling ball following the kick off, the attack continued as he linked up with the forwards. Beardmore battled hard to secure the possession and took us within feet of Cranleigh's line. The solid scrum which followed provided time for the halfbacks to pull off a tight switch sending Ronan in for a try under the posts. This time he converted it.

Excellent controlled possession and setting by the pack and some slick handling supplied 2nd and 3rd phase ball for the backs. The next score came as Sear and Beadmore took the ball into their forwards. Marcus broke left where he passed to Murphy for the try.

Secure ball again from the kick off as the confident forwards controlled the rolling maul. This experience and maturity provided the platform and space for Murphy and allowed the backs to open up. Cranleigh were short of ideas when they had the ball and Guys determined tackling prevented them from even threatening our line. Support was the key to the next try as our centres broke free leading to a scrum 5 yards out. Dipper picked up, popped to Murphy who linked with Ronan, the ball somehow squeezed out to Peter Goodyear who took two tacklers with him as he crashed over.

Shaeffer then decided to leave the pitch with a delayed headache. Hungry for more than 46 points the twos broke again led by Dipper. Beardmore took over as the pack once more set solidly. Slipping

wide to the right, Pete Goodyear dummied the scissors to 'Ginger' Roy, the try was certain had he given it. Following closely however, Marcus picked up brilliantly as Pete was tackled and bundled over the line taking the score to 51. Odd decisions then rounded off the game;a penalty try to Cranleigh 22 yards out, Alan Mislin scoring a try, Pete kicking for position with a 50 point lead and a 7 man overlap.

Good festival Rugby with Guy's running away with a 57-7 victory.

Team: James Bart, 'Real' Roy Sear, Beardmore, Pat Davis, Marcus, 'Ginger' Roy, Dipper, Jon Murphy, Ronan, Mark Howells, Pete Goodyear, Richard, Bill Shaeffer, Matt Rose, Stron.

Patrick Gush
PR Officer

Rugby 3rd XV

Match report

Guy's Hospital 3rd XV v Old Alleynians. 2 October 1993. Won 13-10.
The first game of the 3rd XV season was very encouraging, although there is much room for improvement. Our opposition, Old Alleynians 3rd XV, were one team higher than the opposition of the previous year and so it was with some trepidation that we took the field.

The first half was a close-fought battle with the Guy's scrum dominant but winning little clean ball in the line out. Guy's backs tackled ferociously and Alleynians were unable to break through. Good interplay between Sturgeon and Lewis saw Lewis crash over in the corner, which he was unable to convert. He did later improve his aim to put over a penalty to make the score 8-0 up at half time.

Alleynians were in no way downhearted and scored almost straight from the kick-off. This was promptly converted to leave Alleynians trailing by just one point. For the next 40 minutes the Guy's XV were under constant pressure and again our defence was faultless. Good work by the front row, Angus Fresher and Lams and by Richard Dales in the maul led to a scrum just short of the Alleynians line. Pressure was duly exerted on their pack and Sturgeon forced an error by their scrum and scored. Old Alleynians replied with a penalty but were unable to close the gap further. Guy's finished victorious 13-10.

Team: A Fresher, S Russell, E Lams, R Dales, M Ansell, C Smith, B Eddy, P Pony, J Sturgeon, K Lewis, S Simpson, M Fresher, E Wallis, R Singh.

Simon Russell

UMDS Boat Club
A summary of 1993

The 1993 Boston Marathon--or how not to spend Sunday afternoon
The first major event for the newly founded UMDS Boat Club was also the new club's first tour--the 1993 Boston Marathon. Ever since the summer term, many club members have been talking about 'The Boston', and by the beginning of July, it looked like four VIIIs would be entered--the largest entry by any club. However, subsequent problems led to one of the crews withdrawing, and a scratch IV+ was entered, all finally being decided upon the day before the race.

Saturday morning dawned, and the crews met at our boathouse, to load the boats. As well as transporting our own boats, we also had three others to transport for other clubs, and the problem of moving 30-odd people nearly 200 miles to Lincolnshire. A fleet of vehicles left the club during the afternoon, including a minibus, driven by Ollie Foote (who manfully agreed to drive it at just 24 hours notice), with the final car leaving at 4.00 pm, having retyred two of the the wheels from the trailer. Despite having a fully laden trailer, our Range Rover Discovery made light work of towing, and everyone was safely in Lincolnshire by early evening.

After a meal laid on by our hosts for the week-end, Vice-President Fred Moorhouse and his family, the annual visit to 'Ye Olde Sun Inn' at Retford beckoned, where the boat club's social side shone through. The highlight of the evening was the pool game between Enis 'Hustler' Guriel and Kevin 'Hotshot' Boyd and a much fancied local pairing, who were shown how pool should be played.

The ladies 2nd VIII having completed the Boston

A bright and early 6.30 am start was needed on Sunday morning, the Moorhouse family managing to serve a cooked breakfast to all within 40 minutes, and the crews were able to depart shortly before 8.00 am.

Whilst some people unloaded the boats, others set about taking the vehicles to the finish. The ladies 2nd VIII were first to row, displaying excellent form after their previous training week, organised in an exemplary manner by Jane Neerkin. With an unfamiliar course to contend with, they finished very creditably in a time of 5h 25 mins, the second fastest

college VIII. The full crew was Claire Emery, Annabel Somerville, Jane Neerkin, Ruth Selwood, Sona Biswas, Angela Irwin, Nina Barrows, Nicola Ballard and cox, Keri Hutchison.

The ladies 1st VIII followed the 2nd VIII onto the water by a mere eight minutes. Despite only a couple of pre-race outings, organised by, Chrissie Carey, the crew were rowing well... until Bardney Lock. At this point, the boats must be carried around the lock and down to the lower part of the river. Unfortunately, the ladies' captain, Vanessa Parmenter, hurt her back during this exercise, and cox, Ollie Foote, offered to swap places shortly after leaving the lock. This unfortunate delay must have added several minutes to what would have been, in the conditions, an excellent time. Finishing after 5h 18 min of rowing, the fastest ladies college VIII was Sharon Payne, Vanessa Parmenter, Louise Ward, Michelle Roberts, Chrissy Carey, Amanda Bowman, Emma Parkinson, Julia Thomas and cox, Ollie Foote.

The mens 2nd VIII were next to go, and, despite just one outing since the Bumps in May, this composit crew, organised by John O'Leary, rowed with vigour (in a strange boat) to record the club's fastest time of just over 5 hours. The crew was John O'Leary, Dylan Jewell, Kieron McVeigh, Alex Jeans, Steve Lewis, John Anns, Enis Guriel, Kevin Boyd and cox, Nicky Cohen.

Problems in getting the trailer to the finish meant that the men's Ist IV started one and three-quarter hours late, and 50 mins after the penultimate crew. During this time, the strong head-winds which had been blowing all morning, had increased, and the sky become overcast. The crew (John Robin, Steve Arnold, John Crossman, Andrew Hobkirk and cox, Emma Helm), despite never having rowed together before, made Bardney Lock in 1h 09 min, destined to finish in a time of 5h 30mins. However the lack of practice, no other crews to race against, and a head-wind, which was strong enough to virtually stop the boat at one point, resulted in a final time of five and three-quarter hours, on a day where the fastest time was only just under four hours, and most crews finished in the five to six hour period.

Thanks must go to those members of the committee that have put in a great deal of time and effort to organise 'The Boston' and make the weekend a success. Individual thanks must go to the crew co-ordinators, Chrissy Carey, Jane Neerkin, and John O'Leary for organising and sorting out problems in their individual crews; Ollie Foote for driving the minibus and John Robin for driving the boats around 350 miles there and back; our President Mr Michael Gleeson for his role as chief supporter, John Crossman for heroically agreeing to row the day before the race and finally, our hosts, Mr and Mrs Fred Moorhouse, who put up with around 25 mad-cap rowers for yet another year.

As to the next time.... well, despite the groans of, 'Never Again' on the Sunday, by next summer the memories of the pain will have receded and the lure of the social side of the annual boat club tour to Boston will come to mind.... It's hard to believe that UMDS BC will not be there, with yet more rowers ready to take up the challenge of the River Witham.

The 'Dr Ernest Huddy'

This is the name of the brand new pair/double delivered to the club over the summer and it was felt that the boat should be launched in style.

Dr Ernest Huddy is an old member of the former Guy's Hospital Boat Club, who in 1927 stroked the winning VIII of the Allom Cup, beating Bart's Hospital by three lengths. He is still an active rower, competing in 12 consecutive Sculler's Head of the River Races up to 1989, and, when he won the Veterans division at the age of 80 years, the A R A created a new winners category to honour his achievements.

The new boat is christened

Despite the short notice of just six weeks, over 30 old boys and their families made it down to our boathouse, where they were treated to a champagne buffet. Of over 100 invitations sent out, 80 replied, and every single one, whether formally of Guy's or St Thomas's Boat Clubs, wished the new UMDS Boat Club good luck and hoped that we built upon two former clubs' formidable successes.

After speeches by President Mr Michael Gleeson, Captain Tim Webber, and Dr Huddy (who also wished the new club well), the boat was officially launched. The cracking open of a bottle of champagne over the bows was followed by its first official outing, being sculled past the boathouse by Tim Webber and Dr Huddy's son John, himself a keen sculler.

In conclusion, the afternoon was a great success, and many people must be thanked. First and formost, special thanks must go to the social secretaries, John Swift and Jo Marsden-Williams, who, along with ladies' Vice-Captain Lucy Nicholson, prepared the excellent spread of food. Thanks must also go to Mr Gleeson and Vice-President Mr Donald Bompas for supplying the champagne, and for organising the invitations. Lastly, but by no means least, the rest of the committee and club members who worked hard to make a successful and memorable afternoon.

The first official outing of the 'Dr Ernest Huddy'

Janousek Fours Head

This was the first event of the new term racing over the Tideway from Chiswick to Hammersmith. It has been a regular in the boat club calender for the last few years. The entry of our club was limited to two, due to the shortage of boats. The woman's first IV had a superb row to finish in a time of 14 min 54 s and become the second highest placed crew (after Cambridge University) in their Senior III division. The men's IV, despite just two pre-race practices and a collision near the finish, caused by some diabolical steering from a ladies coxless IV, was the highest placed college. The crew managed to finish second in the division, in a time of 14 and a half minutes, beating a much fancied IV from the London School of Economics into third place.

Head of the River Fours

This huge event took place on 6 November 1993, between Chiswick and Putney. UMDS entered five of the 500 boats racing in this prestigious event. First to row was the ladies Ist quad, who finished well in a time of 25 mins. The men's Ist IV had a good row and despite some difficulties in passing certain crews, returned with a time of just over 24 mins. UMDS also entered two coxed fours. The first crew finished midway in its novice division, with a time of 25:40, although the second crew, in a 15 year old boat, unfortunately failed to finish due to equipment failure. However, it was left to the ladies coxed four to have the best result of the day, taking 27 and half minutes to row over the course, coming second in their division, and a mere 20 seconds behind the winning crew.

University of London Regatta

The morning of the UL Regatta was met with a groan by all those members due to race that day--a couple of inches of snow and bitterly cold winds did not inspire enthusiasm. The mens' novices were the first to bear the brunt of the climate, rowing at an un-Godly 8.30 am. They were very unlucky to catch a crab during the race and lose narrowly to the eventual winners, QMW. The novice IV, drawn from the crew, also suffered the same fate, losing to a crew from the much larger King's College, London. The Ladies' novices fared better beating Bart's and King's, avenging the men's defeat, to easily reach the semi-final.

UMDS entered two men's crews in the open fours and both made the semi-finals where they clashed. Although this meant that one would go through to the final, one had to lose. After waiting ages for a King's boat that never showed, the two crews raced together with the 'A' crew winning by one length, although the 'B' crew, with four rowers competing in the division above their personal level, did not disgrace itself. The 'A' crew went on to claim the runner-up spot in this division, being edged out by another King's crew.

The delay incurred above, though, was to have disastrous effects for the mens senior VIII. Much was expected of this crew, and after promptly disposing of Charing Cross using only six rowers, due to a problem with a seat, the crew looked set to stake a claim for victory. However, after the aforementioned delayed fours race, the crew jumped into the VIII half-an-hour late, only to be told that they had

been disqualified. Protests to UL, not surprisingly, fell on deaf ears, and UCL went on to win, devoid of perhaps their strongest opposition.

The ladies' club also had mixed fortunes, the opening VIII losing to the eventual winners in the semi-final. The senior VIII, after being victims of the UL disqualification policy, were re-instated to their final, after waiting and hour to race and being accused of not turning up! The final itself proved to be spectacular, with the crew losing to UCL by less than a length. Another runner-up spot was achieved by Marcus Newbold and Andrew Hobkirk in the open pair, who should by rights have won after the King's boat (again) caused trouble, by steering right into them and not incurring a disqualification. The open mixed VIII, a scratch crew, also finished second.

UMDS won the sculling events, both men's and woman's titles being taken by our members. Tim Webber defeated a LSE sculler who was getting personal advice from the UL coach and chief umpire during the race while Ruth Selwood won the all UMDS ladies' sculling final.

After such a day, the whole club looked forward to the United Hospitals Regatta with relish, and a chance to avenge defeats.

United Hospitals Regatta

The UH Regatta was contested on another freezing morning, with UMDS defending the Steadman's Challenge Cup won so convincingly by Guy's Hospital Boat Club last year. Our novice VIIIs were first to row, and each managed to reach the final, where both crews were beaten narrowly, the men by Royal Free and the ladies by St Georges.

The woman's 2nd VIII had a good row, and were unfortunate to be drawn against the UCH Ist VIII (the eventual winners) and lose by a mere length. A similar fate awaited the mens 2nd VIII, losing by 1/2 a length to Bart's 1sts.

The open VIII fared better, each finishing second to the London, the men after having a clash of blades with the other finalists. The open mixed VIII also finished in the runner-up spot, losing by a canvas in the final after convincingly beating its first round opposition.

Whilst the VIII experienced mixed fortunes, UMDS was utterly dominant in the smaller boats, with six wins in the six categories. The mens' and womens' open sculls were both straight UMDS vs UMDS finals (with honours going to Tim Webber and Ruth Selwood respectively) as was the men's open pair, this event being, won by Marcus Newbold and Andrew Hobkirk. The men's open IV+ also cruised to victory, the crew of John Robin, Tim Webber, John Anns, Neil Harrison and cox, Emma Helm stamping their authority over the London. The ladies open IV+, Lawrence, avenged their open VIII defeat by beating the London (and UCH) by an emphatic two lengths. The largest winning margin, however, was claimed by the Junior IV+ of Sidd Nene, Steve Arnold, Steve Lewis, Al Morton and cox, Keri Hutchison who crushed the London in the final by a clear four lengths, bringing the total of victories to six and safeguarding the return of the Steadman's Challenge Cup to UMDS. Our nearest rivals, the London, won four events and the winning spoils were shared throughout the Hospital Clubs.

Steve Arnold
Secretary UMDS BC

MB BS (London)

Qualifers for Jan 1994

Abaecheta Miss A
Chan B S-C
Chhaya S C
Down M W F
Gibson Miss E E
Holloway I
Kochhar N
Lal K R
Mosahebi-Mohammedi A
Or Miss C
Parmar H P
Prasad P
Rashid A H
Shafi A
Sharma N K
Walker G D
Dobbie Mrs J

Prizes for Christmas raffle

1st prize
Alison Richardson
1 Farrins Rents
Globe Pond Road
Rotherhithe SE16

2nd prize
Mrs J M Edward
Yew Tree House
Appledore
Ashford Kent
TN26 2BX

3rd prize
Mrs Barbara Lambert BDS
6 Windy Lane
Marske-By-Sea
Redcar Cleaveland

4th prize
Dr G Canty
21 Bannerdale Road
Sheffield S72DJ

5th prize
Mrs Anne Duncan
Hayton Manor
Hayton Road
Stratford
Ashford Kent
TN256D2

6th prize
Dr G D Thomas
48 Fields Park Road
Newport
Gwent NP9 5BH

7th prize
Moorshead
Les Pres
St Pierre-du-Bois
Guernsey
Channel Islands

8th prize
Mr C Howell
Oral Surgery Dept
The West Hill Hospital
Dartford Kent

9th prize
Sue
Guy's Hospital
ext 4259

10th prize
Dr M J R Mackrill
High View
Bigsby Road
Retford
Nottinghanshire DN22 6SE

Holiday flats to let

South Lakeland---nr Kendal. Luxury 2 bedroom flat converted from Shippons of Westmorland Bank Barn. From £170 per week. Central Heating, electricity and bed linen included. Also bed and breakfast. En-suite rooms in converted 18th-Century barn. £17 per person. Pauline Jones 05395-67628.

To Fellow Students

Mr L R Rowland, Guy's LDS 1928, Children's Department house surgeon 1929, celebrated his 90th birthday last year. He would be interested in hearing from any 'fellow survivors'. Down House, Down Lane, Frant, Nr Tunbridge Wells, Kent TN3 9HL.

Birth

GARDNER. On 31 December 1993, to Kate (nee Laughton) and Tony, a son, Jack Stanley.

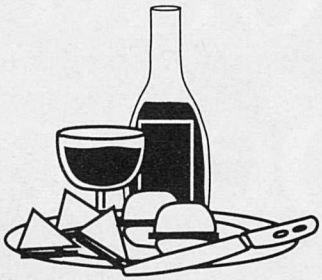
Dental practice for sale

All private practice. Long established. West London. £140 000 gross on three day week. Many patients. £200 000 possible. Superb modern surgery. Excellent technician on site. Retirement sale. Telephone 081 748 6543.

Announcements

Henry Winsley Stolz MB BS, a graduate of Guy's 1950, has been honoured by the Royal College of General Medicine for his contributions to the discipline of General Practise, by being invited to become a full member of the College. He is a principal at 102 Muswell Hill Road, London N10 3LR. He is the founder of the annual Sarah Stolz lecture in Child Psychiatry, Psychoanalysis and the Psychological aspects of Child Health, which he instituted when Sir Gerald Vaughan was the first child psychiatrist at Guy's Hospital, in 1962. He has also become a Patron of the Bloomfield Clinic appeal.

The Pretzel
Patisserie
Sandwich Bar



✳ ***Company Accounts welcome*** ✳

✳ ***Catering for Office Parties*** ✳

Cheapest Cakes & Sandwiches - from 99p

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